Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Emmerson Rice Month 2:45 PM 2012 Medical 68 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Center Maryland University of Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 216-36-4077 Months Hours (Month, Day **Director** 1 **X** M 2 □ F Maryland 72 Dec 10 1939 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Queen Anne's Maryland Sudlersville 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Benton Corner Rd. 21668 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 💢 No If Yes, Give ò Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: 3 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Mechanic City of Annapolis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental item 27 is marked မ William Rice Vida M. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Mary L. Rice(Wife) 1004 Benton Corner Rd. Sudlersville, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metro Crematory 9-4-12 4 Donation 5 Other (Specify) Baltimore, Md. Signature of Funeral Service Licenses Winname Races of SoilitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hemorrhage Onset and Death Physician/ Intracvanial disease or condition 30 hours Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? performe this certificate Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury eral Director: A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. NPI: 1255607554 08 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5 St Baltimore CW State

DHMH 17 Rev 06-2011

Registrar

AUG 29 201

2-06646		Please Type or Print in Bla	ack Indelible Ink. Ensure All Copi	ies Are Legible.			
Beatrice Ann Reiche	enbach	State of Maryland /	/ Department of Health and Mental I	-lygiene	001	0 0 0 0	^
	1- For State Registrar		Certificate of Death	Reg. No.	201	2 300	U
Physician/		Name (First, Middle,Last)		Date of Death Month Day	Year	3. Time of Death	
Medical Examiner	Reatr	ice Anne Reichenhach		September 3, 201	2	0230 hrs	

		1- For State Registrar	C	ertificate	of Death		R	teg. No. 20	112 3000		
Physic		Decedent's Name (First, Middle,Last)					Date of Dea Month	Day Year	3. Time of Death 0230 hrs		
ledical Exam متبر	ıner	Beatrice Anne Rei 4a. Facility Name (if not institution, give			4b. City, Town, o	or Location of D		er 3, 2012			
7		2399 Biggs Highway	street and numbery		North Eas			Cecil			
Funeral		Social Security Number	7. Age (In yr	s. last birthday)	If Under 1 Ye			rth(MM/DD/YYYY)	Birthplace (State or Foreign		
Director		213-76-5420	M 2 X F	45 Y	rs. Months Da	ays Hours	Min. 04/08/	04/08/1967 Country) MD			
A		Usual Residence of Decedent	1400 6	City, Town or Loc	etion				10d. Inside City Limits		
ow any		10a. State 10b. County							1 Yes 2 No		
Maryland 28a-f show 1 at once.	ctor	MD Cecil 10e. Street and Number	No	orth Eas	10f. Zip Code		11	10g. Citizen of Wha			
he Ma 1 or 28 iffed 1	Director	2399 Biggs Highwa	v		21901			United States			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ara	11. Marital Status	12. Was Decedent Ever in		Vas Decedent of H		(Specify Yes or No		American Indian, Black,		
death or ite	Funera	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 X No	۰ _	Yes, specify Cub		ierto Ricari, etc.)				
rs after ural", unier	þ	3 Widowed 4 Divorced 15. Decedent's Education (Specify only	f Yes, Give Year or Dates: y highest grade completed	1 16a Deced	Yes 2 No specify: dedent's Usual Occupation (Give kind of work done			Specify: 16b. Kind of Bus	White iness/Industry		
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	fe. DO NOT use			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
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15-0 lited w Hygie d othe	ပ္ပ	17. Father's Name (First, Middle, Last)					lame (First, Middle,	•			
2121 Ild be i Mental	To Be	Karl Alan Reiche 19a. Informant's Name/Relationship (Typ		19b, Mail	ing Address (Str		Esther S		. State, Zip Code)		
AD 2 show and 1 and 1 is matic	-	Edwina Gilbert /	-				North Ea	-			
Ce, No. 1 and 1 and 1 Health		20a. Method of Disposition			osition (Name of c		Date		City or Town, State		
MOI Pages lent of rothe		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Ch	nerry Hi	11 Metho			Elkton			
Salti srmit. epartm nports jury o		21. Signature of Funeral Service License	e) /	22	. Name and Addre	ss of FacilitR .	T. Foard	Funeral	Home, P.A.		
		23a. Rart I. Enter the disease, or compli	MD 21911								
Physician Medical		failure. List only one cause on eac	h line.		1 110 1110 00 01 07 11	9, 444, 45 -41 4			Between Onset and Death		
Examiner			ardiac Arrhy ue to (or as a consequenc								
	L	Sequentially list conditions, b									
	miner	if any, leading to immediate D cause. Enter Underlying Cause C.	ue to (or as a consequenc	e 01).							
red Insit	Exar	events resulting in death) Last	ue to (or as a consequenc	e of):							
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760, cate be ex physician		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr					23d. Date of d			
certification of the certifica	cia	past 12 months?	1 Live birth 4 Pregnant at time of		etal death 3 Other (Specify)	Ectopic pr	egnancy	Month	Day Year		
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown	9 Unknown		Strict (-p/)						
5, P.O. Box 687 irres that the death certification is gened by the attending the detached for use as t	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the	e underlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown		
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Cords, law requir has been s	Completed						autor perfo	osy pri ormed? de	or to completion of cause of ath?		
Vital Reco ysiclan: The law his certificate has director, page 2 s		25. Was case referred to medical			26 Plac	ce of Death (Ch	1 Yes	2 No 1	Yes 2 No		
/ital	Be		espital: 1 Inpatient 2	ER/Outpatie		Othor	ursing Home 5	Residence 6	Other: Scene		
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Division of Vital Records, tal or Attending Physician: The law require at after death. Al Director: After this certificate has been sided in by the fineral director, page 2 should it.	Certification:	3 Suicide 6 Could not be determined		At home, farm, st	reet, factory, office	building, etc.	28f. Location (or Town, \$		or Rural Route Number, City		
lospita 1 hours 1 hours 2 hours		4 Homicide	n: To the best of my know	ledge death occ	urred at the time	date and place	and due to the caus	se(s) and manner a	as stated		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be deapabed for use as d	Medical	one) 2 Medical Examiner:	On the basis of examination and manner stated								
8 4 8 4	Me	29b. Signature and title of certifier	and marrier stated		29c. Licer	nse number		29d. Date signed	(Month, Day, Year)		
		() Carlakers	>		0.0	:.M.E.		September 3	3, 2012		
		30. Name and address of person who co Laron Locke MD. Assista	ompleted cause of death (It ant Medical Examine		Baltimore Stre	et. Baltimor	e, MD 21223				
Ş	tate	31. Date filed (Month, Day, Year)					_,5				
Regis		G 6	A A	bar							

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year 1305 hrs Lynn Lepaige Stuart 28 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 267-76-3263 67 Director 1 🗆 M 2 🛎 F March 17, 1945 Florida or 28a-f show "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Thurmont 1 Yes XX No 10f. Zip Code 10a. Citizen of What Country? Funeral 14509 Holstein Court 21788 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 Yes 2 No Black White etc. 1 Never Married 2 Married ģ filed within 72 hours after Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes. Give 3 Divorced Completed Year or Dates ed other than "natur event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Educator Education Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other i Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Lepaige ೭ Mabel Weidler other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21788 Timothy Stuart husband 14509 Holstein Court, Thurmont, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Department Important: In any injury or 8-31-2012 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service-Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) 18ars Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-i Physician/Medical Box 68760 as attending use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No ó Month Day Year Pregnant at time of death by the 9 Unknown 9 Unknown P.O. been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform certificate Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 1 🗀 Yes Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and/or investigation in any control of the cause of examination and control of examination and cont

To the Hospital or Attending Physician: hours after within 24 hours a

To the Funeral C

completely filled

29a. Certifier (Check

only one) 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 4

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

19

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	For State Registrar 1. Decedent's Name (First, Middle, in the state of the state o	State of M	larylan		tificate of		Mental Hy	Reg. No	001	2	3000	
cian		Suzanne J. Sch	,					Month August	Pa	^y 20	ear 2	3. Time of Deat 11:50p	
dica nine		4a. Facility Name (if not institution, g				4b. City, Town,		4c. County of Death					
		Northampton Man		_			ederick	s. 8. Date of Bir			deri		
al or	ľ	5. Social Security Number 134–38–3038	5. Sex 7. As 1 □ M 2 🔀 F		ast birthday)	If Under 1 Year Months Day		th iy, Year)	9	. Birthpl Cou <i>nti</i>	ace (State or Fore y)		
٦,		Usual Residence of Decedent		65		Yrs. March						York	
	똤ㅣ	,			y, Town or Loc		10d. Inside City Limits 1 🎛 Yes 2 □ No						
2		10e. Street and Number	roll_	Mt.	Airy	10f. Zip Code			10g. Cit	tizen of Wha	at Count		
1	era	1001 Scotch Hea	ther Avenue	Э			United States			ites			
		11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces?				Hispanic Origin? (S ban, Mexican, Puer						
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3	ωŀ	17. Father's Name (First, Middle, Las	st)		r	lanager	18. Mother's Na	ame (First, Middle,		Sears Surname)			
F	잍	John Schopp					Dorothy	Gou1d		,			
1		19a. Informant's Name/Relationship			19b. Mailing	g Address (Stree	et and Number or R	ural Route Numbe	er, City or	Town, State	e, Zip Co	ode)	
	-	Heather Hardest	y / Daughte				Heather A						
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	ŀ	21. Sign to 4 f Furler / Service Lic	<i>ecity)</i> :ensee ∕ 1	Cem	etery c	Name and Add	ress of Facility					w York	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	•			2012	30007
			Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	ite of Death	2. Date of Death	3 -	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)	1 Casil	7		Month	Day Year	7:45 PM
	/Medio		4a. Facility Name (If not institution, give s	treet and number)	4b. Cit	y, Town, or Location of Deatl	80	4c. County of Death	
	Examir	ıer		ng and Rehab	111. 01	schoton H	bright	Ken	+
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las.	t birthday) If Und	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign
	Director		821-34-3197	M20F 63	Yrs. Month	s Days Hours Min.	9/7/1	1948	DE
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
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	with the Maryland a or 28a-f show Lear Afflied at	Director	10e. Street and Number		1- 01- 11	Zip Code	10	g. Citizen of What Co	untry?
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	death	Funerai		Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	cedent of Hispanic Origin? (S becify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	
و ع	after or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No		2 No Specify:	o i moan, oto.,	Specify:	3
2500	d within 72 nours after death with the Maryla glene. Tritan Tratural', or items 23a or 28a-f show If a Marijoal Exama ne mual to inciffied at	d by	3 Widowed 4 Divorced	Year or Dates:					ack
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. 0.	0 to 0	To B	Frank A. Sri	off, Sr		Aure	e E. C	urlee '	Scott
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, Z	5 = 7 ±	1	Sharon Sco.	1	318 1		orus Ch	-	0691E QH
<u>o</u>	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ce of Disposition (A netery, crematory o	r other place)	Date 2	Oc. Location - City or	Town, State
Baltimor	r. Pa rtmen rtant: njury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Finery Service License	Da		and Address of Facility	3119 H	Indeletan) DC
מ	permit. Pages Department of Important: If i any injury or one	1	21. Signature of Princip Service License	- X	7 D.D	- RN 1503	mod la		E 19805
			23a. Part1. Enter the disease, or complic	ations that caused the death.	Do not enter the m	ode of dying, such as cardiac	or respiratory arres	st.	Approximate
		e 10	shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		7			Interval Between Onset and Death
•	nysician /Medical		disease or condition resulting in death)	Due to (or as a consequer	nce of):	ith diffus	melast	esus	16 month
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	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequer	nce of):				
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200	certificate be nding physicia ise as the bur	edicai	d						
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ָר : כ	w requires that the death certific been signed by the attending p should be detached for use as	Phys	9 🗆 Unknown						
'n	ries m igned be de	by	Part II. Other significant conditions con	tributing to death but not resulti	ing in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to s 2.00 No 3 □ Pro	bably 4 Unknown
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ည	has has	mpi					24a. Was an autopsy perform	24b. Were au prior to death?	topsy findings available completion of cause of
		ပိ	OS Man area referred to medical				1 ☐ Yes 2	©No 1 □ Yes	2 No
Vital	rnysician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3□ I		ath <i>(Check only one</i> Iome 5□ Resider	nce 6 □Other (Spec	cify)
5	grnys erthis eraldir	-	27. Manne of Death		8b. Time of Injury	28c. Injury at Work?	28d. Describe how		,
0	andin aath. or: Aft or e fur	atlo	1 Watural 5 Pending 2 Accident investigation	(World, Bay 10al)	М	1 ☐ Yes 2 ☐ No			
DIVISION	irecto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fact	ory, office	28f. Location (Stree City or Town,	eet and Number or Ru State)	rai Route Number,
ַ	urs af urs af eraf D	O		1-1				(1)	
	I o the trospital or Attending Friys within 24 hours after death. To the Funeral Director: After this c completely filled in by the funeral dir	edicai		sician: To the best of my knowle ter: On the basis of examination and manner stated.					
	orthin orthin omple	Me	29b. Signature and title of certifier		2	29c. License number	29	d. Date signed (Monti	n, Day, Year)
,	> F- 0		> ///llle	m)		D21313		8/16/12	
	3		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Print)				
			KINK, WUN,	MD 415 Wa	ashington	Ane, Chesterto	wn MD	21620	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 16	20 2 \ August A	B. 160	extel			

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pie	ase Type or							egible.	
		For	State o	of Marylar				Mental Hy	giene		
		State Registrar			Cer	tificate of	Death		Reg. No. 2	012	30008
Physicia	n/	Decedent's Name (First, Midd	le, Last)		0			Date of De Month	eath Day	Year	3. Time of Death
Medic		Nancy,	Jorinsa	<u>on</u>	- Oa	MMC	Inn	Augus	+ 27,	2012	2:18AM
Examin	er	4a. Facility Name (if not institutio	n, give street and nun	nber)	- 1	4b. City, Town,	or Location of Dea	th la (4c. Cou	inty of Death	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ay, Year)	9. Birthpl Countr	ace (State or Foreign y)
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land show dat	ō	10a. State 10b. Count	у	10c. Ci	ty, Town or Loc	cation				10	d. Inside City Limits
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the N	₫	10e. Street and Number		Litt	7.011	10f. Zip Code			10g. Citizen	of What Count	ry?
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death item		11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.		Vas Decedent of	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or No-		Race - America	
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Hygi Hygi othel	Be	17. Father's Name (First, Middle,	Last)		1101111	- HIVE	18. Mother's N	ame (First, Middle,			
be fi ental ked ic ev	은	FREDERICK F.	JOHNSON					P. HICK		,	
nould s mai		19a. Informant's Name/Relation	ship (Type, Print) HTT	SRAND	19b. Mailir	ng Address (Stree		ural Route Numbe		n, State, Zip Co	ode)
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b		sition (Name of KEry CREMA		Date		on - City or Tov	vn, State
Page nent c int: If		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other		Otato	INTER	neiory eu tomer pen		31/2012	STEVE	NSVILLE	. MD
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permi Depar Impol any ir		JOHN R	. MER	CERS				T. EASTO			
		23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that	caused the dea		er the mode of dy	ng, such as cardia	c or respiratory a	rrest,		Approximate
Physician/		Immediate Cause (Final disease or condition	_	terstit	Ja 1 1	1	150090				Interval Between Onset and Death
Medical		resulting in death)	a.	(or as a conseq		uns 121	sease				
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To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE:	00 - 15								
th ce ttend or us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnation Birth 2 Fet	al death 3	Ectopic pregna	псу		23d.	Date of deliver Month	y Day Year
e dea the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unk	nant at time of nown	death 5 ∟	Other (specify)				World	July , ou.
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the H in 24 the Fi	Med	(Check 2 ☐ Medical only one) 3 ☐ Certifyir	ng Nurse Practitioner	r: To the best of	my knowledge,	death occurred a	the time, date and	place, and due to	and place, and the cause(s) ar	nd manner as st	se(s) and manner stated. ated.
To t To t		29b. Signature and title of certifi	_			29c. Licen	se number		29d. Date sig	gned (Month, D	ay, Year)
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mi		30. Name and address of person				Print)	01		7		
1 2		Sourik C	hatterjee	180		orleans	Street	balti	more,	Md 2	1287
Stat Registra		31. Date filed (Month, Day, Year) SEP - 4	2012	Registrar's Signa	A ha	, see					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 30009 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Aug 3. Time of Death Day 24 Physician/ 2012 Pheach Srey 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7609 Tarpley Dr. Derwood Montgomery Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Cambodia 8. Date of Birth (Month, Day, Year) **Funeral** 586-48-7551 Months Days Hours Min. 74 **Director** 1 M 2 □ F Yrs. Aug 19, 1938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, th. Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Derwood 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7609 Tarpley Dr. 20855 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin Government. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Soy Srey It Chai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cairo Srey 12108 Brittania Circle Germantown, MD 20874 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Crematory 20c. Location - City or Town, State Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 9/1/2012 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy., Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 MONTHS Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ledical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 🗆 Probably 4 🖾 Unknown 4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No Other (Specify) curred

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and prompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

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Acute Renal Failure	Dye Induced	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Ur								
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Pleural Effusion Rec	urrent	autopsy prior to completion of cau performed? death? 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No								
Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 K Residence 6 ☐ Other (Specify)								
7. Manner of Death 1 🖾 Natural 5 🗌 Pending 2 🔲 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 Yes 2 No	. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200 Disea of laises. At home form atreat featons office	. Location (Street and Number or Rural Route Number, City or Town, State)								

(Check	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and	d title of certife	29c. License number	29d. Date signed (Month, Day, Year)								
Maket H Luard MD D0055522 8/24/2012											

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert H. Gerard, MD 1500 Forest Glen Road Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

AUG 3 0 2012

32 Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month August inner 2012 0015 23 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Memorial Hospita Talbot EASTON 5. Social Security Number 2 18-84-639 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 1 1 M 2 □ F 3 Maryland 10a. State 10b. County 10c. City, Town or Location Director the Medical Examiner must be notified 1 Yes 2 No 10e. Street and Number ច់ 10g. Citizen of What Country? Funeral U 5 A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Mamied 2 Married δ altimore, Maryland 21215-0036 1 Yes 2 No Specify: 131acK Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is merked other than Elementary/Secondary (0-12) College (1-4 or 5+) te Worker #07

18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be ree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Department of Health ar Important: If item 27 is eny injury or other trau Street Apt.29 estree inner 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mid Shore Crematical Center
by Reman Coole P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗹 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) ambrida 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME MD.21613 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 4 cute on chronic Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-transit Due to (or as a consequence of): and that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical utto-cle Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant Pregnant at time of death 5 Other (specify) Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1. Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in proceedings to the control of the cause (s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D72893 23,2012 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) hernet Teklemichael 2195 Washington St, Easter, MD21601 31. Date filed (Month, Day, Year) AUG 30 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Day 9 Physician/ 2012 5:15 A M Steven Langley Smullen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Girdletree 6945 Cherrix Road 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 M.D. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 M 2 D F 100 1/2 1 1 1 9 5 2 MD 59 212-66-2146 Director Jsual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Worcester Girdletree 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 6945 Cherrix Road 21829 USA 2 should be filed within 72 hours after death ith and Mental Hygiene.
27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 \square Never Married 2 \square Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Noivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Smullen Dorothy Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Todd Smullen - Son 8018 Jones: Hastings Rd. Parsonsburg, MD. 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) State Crem.: 08/30/12 MIllsboro, De 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Lig 08 William St. Berlin, MD. 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Year Day Pregnant at time of death detached g Unknown The law requires that the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Tes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ZINO Other: Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accid-5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventioning in a supplication in a stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

OUALL

AVID

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

BASTAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTH M. SHOCKLEY 0916A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSULA NICOMICO Centa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours 221-28-9289 09/119/11943 Director 1 □ M 2 🏝 F 68 DELAWARE 28a-f short 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified of Directo DELAWARE SUSSEX MILLSBORO 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 19966 UNITED STATES 400 BLAISE AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc ō þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify: Yes. Give Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SERVER FOOD SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked o ည CLARA STEELE WILLIAM HAMMOND 19a. Informant's Name/Relationship (Type, Print)
DONNA WALLER/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22010 ESKRIDGE ROAD, BRIDGEVILLE, DELAWARE 19933 1 and 2 s of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Importent: If It eny Injury or o once. 2 X Cremation 3 Removal from State 1 🔲 Burial-MELSON SECREMATORY 09/02/2012 FRANKFORD, DELAWARE 4 Donation 5 Other (Specify) 21. Signature of Fu MEĽSUNndFÜNERÁĽ KERVICES, LTD. 32013 LONG NECK ROAD, MILLSBORO, DELAWARE 19966 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart faili Physician/ MULTIORGAN SYSTEM disease or condition Medical resulting in death) Examiner NUCAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Exami burlal-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 as the IF FEMALE USB USB 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 ANO
9 Unknown ₫ Month Day 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, cete has been siç ; page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA he Hospitel or Attending Phys in 24 hours after death. he Funerel Director: After this o pietely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) To the To the 29b. Signature and title of certifier Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA3 ma 31. Date filed (Month, Day, Year) State 32. Registrar's Signature **SEP** 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dolores Marie 31 Pay Spilman August 20T2 10:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester . Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 213-30-8218 79 1 M 2 X F Aug. 2, 1933 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Dorchester Secretary 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Main Street Apt. A 21664 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) secretary hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Schrandner Edgar Amrhein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Spilman P. O. Box 563, Secretary, MD 21664 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 $\overline{\mathbf{x}}$ Cremation 3 \square Removal from State Crematory of Delmarva 9/4/12 Delmar. DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DISEASE Ph_sician/ A theros devotic HRTERY CORONARY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Die to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 P Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe Yes 2 No 1 Yes 2 🛕 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

503 BYRN

MD

and address of person who completed cause of death (Item 23a) (Type, Print) ERRABOLU

29c. License number

D 69234

2012

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MARYL AIND

CAMERIDGE

	1- For State		Health and Mental		201	2 3001	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Terry 1	Lane Stemple		2. Date of Death Month September 3		3. Time of Death 1930 hrs	
	4a. Facility Name (if not institution, give street and num 2397 White Church Steyer Road	ber) 41	o. City, Town, or Location of Dea Oakland	ath	4c. County of Death Garrett		
Funeral Director	214-78-4309	Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year If Under 24H Months Days Hours M	Irs. 8. Date of Birth (I lin. 11/29/	nplace (State or n MD ntry)		
nd Show any ICS.	Usual Residence of Decedent 10a. State MD Garrett	10c. City, Town or Locatio	n Oakland			10d. Inside City Limits 1 Yes 2 No	
death with the Maryland ritems 23a or 28a-f show must be cotified at once.	10e. Street and Number 2397 White Church Steyer Road		10f. Zip Code 21550	10g.	10g. Citizen of What Country? USA		
	11. Marital Status 1 Never Married 2 Married Armed Ford 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade	res? If Yes 2 1960 - 1993 1 \tag{1}	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer (es 2 No specify: S Usual Occupation (Give kind of	to Rican, etc.)	14. Race - Americ White, etc. Specify: Sb. Kind of Business/In	White	
5-0036 ed within 72 hour lygiene. other than "aatu the Medical Exan Completed	Elementary/Specondary (0-12) College (1-4	or 5+) during mos	st of working life. DO NOT use n Flagman	etired)		ighway	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medica TO BE Comple	17. Father's Name (First, Middle, Last) Clarence W. S			ne (First, Middle, Maic Della I		To Code)	
and 2 should and 2 should dealth and Me titem 27 is ma traumatic er	19a. Informant's Name/Relationship (Type, Print) Della Mae Stemple / mother 20a. Method of Disposition	20b. Place of Dispositi	Address (Street and Number of 2397 White Church on (Name of cemetery,		Dakland, MD 2		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by F	1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Na	r place). Memorial Gardens me and Address of Facility ock-Fredlock Funeral Ho	9/7/2012 me, P.A. 21 North	Oaklan h Second Street, O		
Physician Intedical Examiner	or condition resulting in death) Due to (or as a consequentially list conditions,	Cardiovascular Diseasonsequence of):		or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death	
executed an and al - transit ical Examiner	if any, leading to immediate cause Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co						
ox 68760, ath certificate be attending physici or use as the burisician/Med	23b. Was decedent pregnant in the past 12 months?	t at time of death 5 Othe	death 3 Ectopic preg	nancy	23d. Date of delivery Month Da	ay Year	
Records, P.O. Bo : The law requires that the der ficate has been signed by the a ; page 2 should be detached for Completed by Physical	Part II. Other significant conditions contributing to d Chronic Alcoholism	eath but not resulting in the und	derlying cause given in Part I.	1 Yes 2 24a. Was an autopsy	24b. Were auto		
Division of Vital Records, tal or Attending Physician: The law requing a fare death. al Director: After this certificate has been sight of the funeral director, page 2 should be artification: To Be Completed.	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inp	atient 2 ER/Outpatient	26.Place of Death (Chec	k only one)	d? death? No 1 ✓ Yes sidence 6 ✓ Other:		
Division of a spital or Attending Phours after death. The state of the following Phours after the following phouse of the foll	27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of (Month, D.)	Injury 28b. Time of Injury 28b. Time of Injury 4th number 18b. Time of Injury - At home, farm, street,	1 Yes 2 No	28d. Describe how	injury occurred	al Pouta Number City	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Suicide Gould not be determined (Specify) 29a. Certifier (Check only 1 CertifyIng Physician: To the best of the control of th	f my knowledge, death occurre	d at the time, date and place, ar	or Town, State	and manner as stated	1.	
2	29b. Manuel and title of certifier 29b. Manuel and title of certifier 30. Warne and address of person who completed cause	ed.	29c. License number O.C.M.E.	29	place, and due to the od. Date signed (Mont eptember 4, 201	h, Day, Year)	
TVA	Laron Locke MD. Assistant Medical E	·	imore Street, Baltimore,	MD 21223			
Registrar DHMH 17 Rev 1/2001	SEP - 5 2012						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1604 pm <u>Steven Charles Sacks</u> August 25 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ft.Washington Hospital Center Washington Prince Georges 8 Date of Birth Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthdav) 1 X M 2 🗆 F Mar. 23, 1948 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Clarke <u>Berryville</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 332 West Main Street 22611 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Black, White, etc. 2 XNo 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Lake Braddock life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Secondary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20h Place of Disposition (Name of

Myocardia

cemetery, crematory or other place)

Tede Schatz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 142 Blackberry Drive Stamford, CT. 06475

Riverview Crematory Aug. 31,2012 Old Saybrook, CT. 06475 22. Name and Address of Facility Leo P. Gallagner & Son FH 2900 Summer Street Stamford, CT. 06905

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Physician/ Medical Examiner

Department of Health and Ments Important: If item 27 is marked any injury or other the one

Physician/

Examiner

Fur eral

Director

works + or 28a-f shov notified at

and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be i

Maryland 21215-0036

Baltimore,

Medical

10a. State

VA.

Barney Sacks

Lynn

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Cause (Disease or iinjury that initiated events

resulting in death) Last

disease or condition

resulting in death)

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

(Sister)

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.

Acute

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

Lake

4 ☐ Donation 5 ☐ Other (Specify)

Director

Funeral

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Completed

Be

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Exai

and burialphysician the burial se as to ō the signed by t has this

that the death certificate be Box 68760

P.O.

Division of Vital Records, or Attending Physician: 24 hours after death. Funeral Director, After thi leted filled in by the funeral Hospital

Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check **Certifying Nurse Praction** 29d. Date signed (Month. Day, Year) 28 112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIVINGSTON RD. FT. WASHINGTON, MS ZOT44 atric 3 0 2012 **ORIGINAL**

Registrar

Dana Anthony Sweet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 30016

		1- For State Registrar		Cert	ificate of	Death		, ,	Re	ے کے g. No.) _	3001
Physici	an/	Decedent's Name (First, Middle						M	ate of Death	n Dav Yea	.	Time of Death
Medical Exami	ner	DANA ANTHONY				0.7. 7-		Se	eptember	8, 2012		2009 hrs
		4a. Facility Name (if not institution 5388 Marlan Drive	n, give street and number,		1	b. City, Town, Trappe	or Location (or Death		4c. County of	or Death	
Funeral			6. Sex 7. Ag	e (In yrs, las	st birthday)	If Under 1 Ye	ear If Unde	er 24Hrs. 8.	Date of Birth	n(MM/DD/YYYY	9. Birthol	lace (State or
Director		007-58-5758	1X M 2 F	49	Yrs.		ays Hours	Min	10/19		Foreign	S YLVANIA
		Usual Residence of Decedent	1 - W 2 F		115.				10/19	/1902	FEMI	BILVANIA
any		10a, State 10b. County		10c. City, T	fown or Location	on					10	d. Inside City Limits
	_	MD TA	LBOT]	TRAPPE						1	Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of 5388 MARLAN DRIVE 21673 USA									at Country	?
the N	히											
death with the Maryland or items 23a or 28a-f sho must be notified at once	ם	11. Marital Status	12. Was Decedent			Decedent of H						Indian, Black,
death or ite	Funera	1 Never Married 2 Ma	1 Yes 2	X No	l	es, specify Cub			ii, etc.)	White		TOD
s after ral",	5		orced If Yes, Give Year or Dates:			Yes 2X N				Specify:		ITE
hour fatu	E G	 Decedent's Education (Spec Elementary/Secondary (0-12) 	College (1-4 or		16a. Decedent during mo	's Usual Occup st of working li			ione	16b. Kind of Bus	siness/Indu	istry
36 nin 72 then	ompleted	12	3		MERCHA	NT MART	NE			ENGIN	FFRTN	C
5-00 led with tygien other	S	17. Father's Name (First, Middle,				.,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		's Name (Firs	t, Middle, M	aiden Surname)		0
21215-0036 Ult' be filed within 7 Mental Hygiene. marked other than	Be	WILLIAM SWEET					ARL	ENE RI	NGER			
Shoul? be filed within and Mental Hygiene.	흔	19a, Informant's Name/Relationsh	nip (Type, Print)		19b, Mailing	Address (Stre	eet and Num	nber or Rural	Route Numb	per, City or Towr	n, State, Zip	p Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		CAROLE R. SWEE	T, WIFE			8 MARLA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St		ace of Dispositematory or other		emetery,	Dat	e	20c. Location -	City or Tov	wn, State
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		4 Donation 5 Other Spo	ecify:		SAPEAKI	E CREMA	TION	9/11/2	2012	STEVEN	SVILI	LE, MD
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Physician Madin		23a. Part . Enter the disease, of c failure. List only one cause of		the death. I	o not enter the	e mode of dyin	g, such as c	ardiac or resp	oiratory arres	st, shock, or hea		Approximate Interval Between Onset and
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)	a Atherosc1			ovascu	lar Di	isease				Death
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760, icate be ex physician the burial.	릙	IF FEMALE:	23c. If yes, outcor							23d. Date of o	delivery	
587 srtifica ling p		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	al death 3	Ectopic	pregnancy		Month	Day	Year
Box 68 death certifine he attending of for use as	Si	1 Yes 2 No 9 Unkr	4 Pregnant at	time of deat	th 5 Oth	er (Specify)	-			1		
that the de detached i	Physician	Part II. Other significant condition		but not res	ulting in the un	derlying cause	given in Pa	nrt I. I.:	23e. Did tob	acco use contrib	oute to the	cause of death?
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Records, P.O The law requires that to ficate has been signed by page 2 should be detace	Completed						_	— -	24a. Was ar			sy findings available
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ath.	힐	1 X Natural 5 Pendi		ear)		1	Yes 2	No				
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Div ppital or ours afte neral Dir filled in	Certification:	4 Homicide						,	or Town, Sta	ate)		
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certif hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending nipletely filled in by the funeral director, page 2 should be detached for use as		20a Codifier	ysician. To the best of m	y knowledge	e, death occurre	ed at the time,	date and pla	ice, and due t	o the cause	(s) and manner	as stated	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner: On the basis of examination and manner stated.	mination and	d/or investigation	on, in my opinio	on, death occ	curred at the t	time, date a	nd place, and du	e to the ca	ause(s)
	ž	29b. Signature and title of certifier					nse number			29d. Date signe		Day, Year)
	O.C.M.E. September 9, 201							9, 2012				
		30. Name and address of person v		,		04" / 5		4D 04000				
		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
St Regist	~~											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month Francisco Arturo Saravia Medical 08/21/ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's 8109 Tahona Drive Apt 1 G 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 🕅 M 2 🗆 F Months Min 33 Director None Sal /28/78 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director Prince George's 1 ☐ Yes 2 🄀 No Hyattsville 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 8109 Tahona Drive Apt 1G E1Salvador 20782 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or δ Maryland 21215-0036 1 🛛 Yes 2 🗆 № EspeciSalvadoran If Yes, Give Year or Dates Specify: White 3
Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Juana Bautista Saravia Unknown traumatic t. Page 1 and 2 should be thrent of Health and Mer trant: If item 27 is marke njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Avalon Place Hyattsville, MD 20784 Rosa Saravia aunt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 09/01/12 Jardin Fuente Salinas El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Philip D. Rinaldi FuneralSvc. any 9241 Columbia Blvd. Silver Spring MD20910 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart faile Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or wa consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial gransit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death ☐ Pregnam of Unknown signed by the a 1 | Yes 2 | 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 autopsy performe Division of Vital within 24 hours after death.

To the Funeral Director, After this certific Completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 1
Natural 5 Pending with 1730 August 21,200 Investigation Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Boute Number, City or Town, State) \$15 9 1 4 4 5 7 5 7 7 4 Homicide determined home Medical The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.

The dical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one)

State Registrar 29b. Signature and title of certifie

onth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Registrar's Signatu

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2012 Sanzaro ам 28 2:40 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6905 Forest Hill Drive University Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 049-01-5267 Country) Director 1 🖾 M 2 🗆 F 96 1915 Oct. 22, Connecticut permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantai Hyglens. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at gones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland P.G. University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 6905 Forest Hill Drive 20782 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 SpecifWhite 1 Yes 2 No Specify. Completed 3 2 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Surgeon Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sebastiano Sanzaro Lucia Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Francis J. Sanzaro/Son Cormer Court, Unit 104, Lutherville-Timonium Baltimore. 20a. Method of Disposition Date 31, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cemetery 1X Burial 2 Cremation 3 Removal from State Aug. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Tichard L. Hates 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Dementia disease or condition vrs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): pata has baan signad by tha attanding physician and page 2 should be datached for usa as tha burlai-transit The law requires that the death cartificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown <u>Р</u> О Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No this cartificata s aftar daath.

I Director: Aftar this cartified in by the funarai director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 70 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 A Natural 5 Pending injury ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide To the Hospital or Atta within 24 hours aftar day To the Funaral Director compistally filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melanic Reynolds A
31. Date filed (Month, Day, Year) 1 2012 32. jegistrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Michael Alexand		Smith Sta	ate of Maryla		artment of		d Mental I	Hygiene	eg No. 2 (012 3001
Physicia		Registrar 1. Decedent's Name (First, Middle	Last\	Ce.	runcate or	Death		2. Date of Dea	.cg. 110.	3. Time of Death
Medical Exami		Michael	Alexand	er	Smit	h		Month August 29		
		4a. Facility Name (if not institution	. •	mber)	1	b. City, Town, or I	Location of Dea	ith	4c. County of	
Eurosol		Doctor's Community H 5. Social Security Number		7. Age (In yrs. I	last hirthday)	Lanham If Under 1 Year	If Under 24H	re 8 Date of Ri	Prince G	9. 8irthplace (State or
Funeral Director			1 M 2 F	7. Age (III yrs. I	44	Months Days	-	_		Foreign
		577–98–5694 Usual Residence of Decedent	I Z F		41 Yrs			04-02	-13/1	Washington, DC
yany		10a. State 10b. County		10c. City	, Town or Locati	on				10d. Inside City Limits
land f show	ö	Md. P.O	3.	F	t. Wash	ington				1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 23 Arthur Drive	Wort			10f. Zip Code	4	[1	10g. Citizen of Wh	•
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after d	J. F.	3 Widowed 4 Divo	rced If Yes, Give Year		1	Yes 2 No	specify:		Specify:	Black
hours matur	ed t	15. Decedent's Education (Spec				s Usual Occupations of working life.			16b. Kind of Bu	siness/Industry
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5-0036 led within 7 Hygiene. lother than	E	17. Father's Name (First, Middle, I	_ast)					ne (First, Middle,	Maiden Surname)	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Be (Ronald		Smith			Lafond		Bla	
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md 2 sealth a com 27		Amy Jones-Smith 20a. Method of Disposition	ı - Wife	20h		thur Driv		, Ft. Wa		city or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation		m State	crematory or oth	er place)				
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Box 68760 e death certificate I the attending phys	Physician/M	past 12 months?	I CIAG DII	rth int at time of de	noth -	al death 3 ∟ er (S <i>pecify</i>)	Ectopic pregi	nancy	Month	Day Year
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IVISION Or Attentable death Director:	ifica		not be 28e, Place	of Injury - At he	ome, farm, stree	t, factory, office bu	uilding, etc.			er or Rural Route Number, City
Divis Hospital or At Hours after d Funeral Direct	Certification:	4 Homicide determ						or Town, S	state)	
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To the within To the comple	Medical	29b. Signature and title of certifier	and manner sta	eted.	ind/or investigati			at the time, date		ed (Month, Day, Year)
	-	235. Signature and the or certifier	le of certifier 29c. License number 29d. Date signed (A August 30, 201							
3,194	-	30. Name and address of person v	who completed cause	of death (Item	1 23a)				1	
			ssistant Medica			altimore Stree	et, Baltimore	e, MD 21223		
Sta	ate	31. Date filed (Month_Day, Year)	2017 32/Rec	istrar's Signatu	9. Sav	Res				
Regist	rar	SEP W	THIS CAN		2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Belita C. Scrivner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE BURNUE ACHINGTOMMEDICAL MER GLEN AHINE . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-66-5829 58 Director 1 🗆 M 2 🗓 F 16, 1954 Marvland Usual Residence of Decedent ir then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10c. City, Town or Location Director MD Anne Arundel Odenton 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 490 N.Patuxent Rd.. 21113 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. à 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "ne eny injury or other treumetic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Johnson Anna Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard James / Brother 610 Rollin Hill Walk, #103, Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/1/2012 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Services Licensee 22. Name and Address of Facility Beall Funeral Home |6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ uzost Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burlal-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use es the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 24 hours after death.

Funerel Director: After this certificate I letely filled in by the funeral director, pagr Ves 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one eted cause of death (Item 23a) (Type, Print) Name and address of person who cop Glen BWMe Hocorba 10 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Gordon Swain Thomas 10:06 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dorchester Chesapeake Woods Center Cambridge If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min **Director** 218-34-8352 1 X M 2 □ F 74 2-14-1938 DE Usual Residence of Decedent or 28a-f sho 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Dorchester Cambridge 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21613 101 <u>Aurora Street</u> . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ <u>Vocational</u> Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ William W. Thomas Evelyn S. Wingate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Aurora St. Cambridge, MD 21613 Melanie Thomas/wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of F Important: If ite any injury or ot once. 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Midshore Center 8/27/2012 Cambridge, MD permit. 21. Signature of Funeral Prvice Licensee 22. Name and Address of Facility 308 High St Newcomb&Collins FH Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PANCREATIC Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): the attending physiciar Physician/Medical requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ fo in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 should be Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has page 1 ☐ Yes 2 🎾 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 [ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 \(\sime\) Yes the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, MD D69234 20 22 2012 e and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

JEEVAN

AUG 24

31. Date filed (Month, Day, Year)

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MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25^{Day} 2012^{Year} Month 08 Dean Rankin Taylor 11:55p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartland Health Center Hyattsville Hyattsville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🙀 M 2 🗆 F Days 12/02/1949 West Virginia Director 232-78-2119 Usual Residence of Decedent th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Completed by Funeral Director WV Ranson Jefferson 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 E. 11th Ave. 25438 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married within 72 hours after 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😡 No Specify: Black Specify: 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 Is marked other th 12 Self Employed <u>Deliverymann</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rankin Adam Taylor Edna Alene Braxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Alger - Friend 516 E. 11th Ave., Ranson WV 25438 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 108/31/2012 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.

Coithersburg, MD 20877 21. Signature of Juneral Service Licensee MD00956 Thibadeau Mortuary Service, 7 Park Ave. Gaithersburg, No. 1 Park Ave. Gaithersburg, No. 2 Park Ave. Gaithersburg, No. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a sur sequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-Light of the complete of the state of the complete of the state of the complete of th attending physician and for use as the burial-the that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Certificate: To 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and its of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08/29/2012 D47867 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG

Oney Zuniga, 4701 Randolph Rd., Suite 216, Rockville, MD 20852

32. Registrar's Signature

Amend	iten	n#	4a, 5, 1	⁰ ⊖Plea	cil CO se Type or	Health Print in	BIBERT	īdĕĤōI	2/h	√. 2 01	are A	II Copie	s Are	e Legi	ble.		
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	Physicia	ın/	1. Decedent's Name		,							2. Date of De			Year	3. Time of	Death
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Mar 2 shou	Ith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) Mark Thomas (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, C 2990 Siwanoy Drive, Edgewood, 1														
Baltimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> once.		20a. Method of Dispo		3 Removal from		lace of Dispo emetery, cren	sition (Nam	e of			ate	20c. L	ocation - 0	City or Tow		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death September 1 Physician/ Kochan rma 2012 3:58A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** arroll Hospital arroll West minster Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 176-22-2267 1 🗆 M 2 🛛 F **Director** 83 12-26-1928 PA Usual Residence of Decede iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🄀 No MD Carroll Eldersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Ridenour Way East 3C 21784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. er than "natural", the Medical Exar SpecifyWhite 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumain. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Secretary MD Book Exchange Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Pawlikowski John Poloski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Learmouth/daughter 14730 Triadelphia Mill Rd Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Crem. Center of MD 9/4/2012 Hanover, MD 4 Donation 5 Other (Spepify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Sign were of Funeral Service Linense more 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or as a consequence of): Physician/ Preminana disease or condition Medical resulting in death) **Examiner** 18it with Multi Organ Dy Function Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Acute burial-transi Renal Fai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day signed by the at Id be detached for 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ metustatic Cancer unknown 1 Yes 2 No 3 Probably 4 Unknown Completed should peen trypertension, typerlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Hospital or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ppatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and bit of certifier 29d. Date signed (Month, Day, Year) Sepkuker 1 D69086 MO 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

CHINTU SHARM

SEP 0 4

31. Date filed (Month, Day, Year)

MD

Carroll Hisportal Center

egistrar's Signature

200 memorial Ave, Westminker MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30025 Reg. No. 20 = State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 4:30p ^M 8 2012 Leon C. Thomas Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Forestville Rehab Center Forestville Prince Georges 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral Director** 578-38-8708 1 🙀 M 2 🗆 F 86 6-23-1926 DC Usual Residence of Deceden or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Director 1X Yes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be Funeral 23a 1611 28th Place SE 20020 United States or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? 1 ★ Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married <u>6</u> Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. If Yes, Give 'natural", 3 Widowed 4 Divorced Completed Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 l and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 12th DC Superior Court Office Service Supporter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Williams James Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1611 28th Place SE Washington DC 20020 Mary A. Thomas/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Virginia 8-27-2012 Quantico National 22. Name and Address of Facility John T. Rhines Funeral Home nature Funeral Service 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Cardiovascular Disease disease or condition resulting in death) Medical Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Adult Failure to Thrive that initiated events Due to (or as a consequence of resulting in death) Last burialattending physician for use as the buria Medical death certificate be Respiratory Failure P.O. Box 68760 as 1 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other:

To the Hospital or Attending Physician: The law i within 24 hours after death.

To the Euneral Director; After this certificate has I to the Euneral Director; After this certificate has I with the funeral director; page 2. Division of Vital

FSM

9a. Certifier 1 Let Certifying Physician: To the best of my knowledge, death occurre	ed at the time, date and place, and due to the t	ause(s) and manner as stated.
(Check 2 Medical Examiner: On the basis of examination and/or investigation	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
only one) 3 Certifying Nurse Fractioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
b Signature and title of ertifier	29c. License number	29d. Date signed (Month, Day, Year)
a Jamo	D31528	8-24-2012
D. Name and address of person who completed cause of death (Item 23a) (Type, Print)		

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at work? 1 □ Yes 2 □ No

4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6128 Landover Road Cheverly Maryland 20785 Margaret Akpan, MD

2. Registrar's Signa

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28a. Date of injury (Month, Day, Year)

1 🗌 Yes

27. Manner of Death

X Natural

4 Homicide

29a. Certifier

Accident

Suicide

ည

Certificate:

Medical

2 No

5 Pending

Investigation 6 Could not be

determined

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ August 20, 2012 Willard Van Beek 5:59 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village at Rockville Rockville 5. 49cial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours -03-9606 90 Director 1 🖾 M 2 🗆 F March 21, 1922 Oklahoma permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hyglene. Importent: If Item 27 is marked other than "netural", or itema 29a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Saddlerock 20902 USA Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. 1 Never Married 2 Married ۾ SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: If Yes Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Curator of Old World Archaeology-Smithsonian Institution College (1-4 or 5+) Elementary/Secondary (0-12) Archaeologist Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Gus W. Van Beek Dovie Crupper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ora Van Beek/Wife 15 Saddlerock Court, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State PafkItawfierMemorrate Aug 26, Rockville, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Va Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physician end for use es the burlal transit that initiated events resulting in death) Last cal P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death signed by the el Part II. **Qther significant∕conditions** contributing to de≰th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1/2 Records, 1 Yes 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physicien: I within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Beath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatu and title of certifier . License number 21726 Nugust 20 a DONGF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26033 Ridge Road, Damascus, MD 20872 Charles Karesh, MD

State

Registrar

31. Date filed (Month, Day, Year)

AUG 27

32. Registrar's Signature

I2-06623 Roselyn Sanchez-	٧,		e or Print in B						.egibl				
Roselyn Sanchez-		- For State	ate of Maryland		ent of He ate of De		nd Menta	ll Hygiene	Dec No		2 3002		
Physician	1/	Registrar 1. Decedent's Name (First, Middle						2. Date of D	Day	Year	3. Time of Death		
Medical Examine		Roselin Sanche 4a. Facility Name (if not institution		Septem	ber 2, 2	c. County of Deat	0821 hrs						
	H	Prince George's Hospi			- 1	Prince Georg							
Funeral Director		5. Social Security Number 673–68–4562	V/DD/YYYY) 9. Bi Forei Co	rthplace (State or gn Maryland puntry)									
, any	-	Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	or Location						10d. Inside City Limits		
<u>k</u>	5	Maryland Prince	e Georges	Lanha	m						1 Yes 2 No		
or 28a-f	Director	10e. Street and Number			10	f. Zip Code	_		_	tizen of What Cou	intry?		
s 23a o	<u>ē</u>	9207 Alcona Str	12. Was Decedent	Ever in U.S.	I 13. Was De	20706		? (Specify Yes or	US.		ican Indian, Black,		
death v	Funeral		White, etc.										
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5-0036 iled within Hygiene. I other than	Ē	0]	N/A				N/A			
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical		17. Father's Name (First, Middle, I Vicente Sanchez						lame (First, Middle n Vera	e, Maider	n Surname)			
O % B = € _	2	19a. Informant's Name/Relationsh Vicente Sanchez		19	b. Mailing Add	lress (Stre Lcona	et and Numbe St. La	r or Rural Route N nham, MD	lumber, 0 207	City or Town, State	ə, Zip Code)		
Baltimore, MI permit. Pages I and 2 s Department of Heath a Important: If item 27 injury or other traum		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe	T IGATE OF HEAVEN CEM. 109/						2 Si	Location - City or 1ver Spr Mary I	Town, State ing, and,		
Saltin ermit. I epartm nports ijury o	t	21. Sign are of Funeral Service L	icensee	1	22. Name	and Addres	s of Facility	Rendon/R	ale.	Funeral			
Physician	÷	23a Part I. Enter the disease, or c	complications that caused	the death. Do no		_					Approximate Interval		
/Medical Examiner	1	failure. List only one cause of Immediate Cause (Final disease	orreach line. a. <u>Sudden Un</u>						,	,	Between Onset and Death		
- C		or condition resulting in death)	Due to (or as a conse	equence of):									
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Box e death the atte ted for u		1 Yes 2 No 9 Unkn	9 Unknown										
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Division of To the Hospital or Attending Physician 24 hours after death. To the Fuoeral Director: After to completely filled in by the funeral Medical Certification:			visician: To the best of my iner:On the basis of exar and manner stated.										
E S F 5	Ē	9b. Signature and title of certifier	11 11	1		29c. Licens				Date signed (Moi			
	-	0. Name and address of person w	the completed cause of d	eath (Item 23a)		O.C.	IVI.⊏.	_	Sep	otember 3, 20	12		
		Jack Titus MD. / Depu	ty Chief Medical E	xaminer 90	00 W. Balti	more Str	eet, Baltim	ore, MD 2122	3				
State Registra	e :	SEP 0 5 2012	32. Registra	's Signature	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year J. VAT August 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CHESTERTOWN KENT Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours Min Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he marified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Grove 1 Yes 2 No 10g. Citizen of What Country? AVONdale US Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 8/15/43 Year or Dates 1 Yes 2 No 3 - Widowed 4 - Divorced Specify Specify: White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mushroom Be 17. Father's Name (First, Middle, Last rst. Middle, Maiden Surname Avondale 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 21. Signature of Funeral Service Licensee Collins 19363 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on earths. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a insequence of **Examiner** Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury Examine burial-tran that initiated events resulting in death) Last Due to (or as a co attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ detached for Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death put not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 0042688 no completed cause of death (Item 23a) (Type, Print) Osdis OH words 1.99 BROWN ST 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		artment of H <i>tificate of D</i>			giene _{Reg. No.} 2 ()	12	30029				
	rsicia		Decedent's Name (First, Middle, Law Wardy Woodrow W	,	(N K N	-Wordy)		2. Date of Dea Month	ath Day	Year	3. Time of Death				
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<u> </u>			Anne Arundel Med			Annap				Anne Arundel					
Fun Dire	eral ctor		5. Social Security Number 6. S 250–78–4149	ex 7. Age (In y)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	, Year)	Coun	**				
p Mo			Usual Residence of Decedent 10a, State 10b, County					03/29/	1945	`	erboro, S.C.				
arylan a-f sh	ified a	Director		George's	City, Town or Loc Bowie	ation				1	0d. Inside City Limits 1 Yes 2 □ No				
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Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show	Examiner	<u>۾</u>	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 12XYes 2 No If Yes, Give 197 Year or Dates.	If	Vas Decedent of His Yes, specify Cubar ☐ Yes ※ No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, e : Blac	etc.				
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□ = 2	or other traumatic		JoAnne Green Wean	s/Wife		Waesche				2072					
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baltimory permit. Page 1 a Department of H Important: If ite	injury e.	ł	1. Signature of Funeral Service Licensee CCC0316 Chesapeake Crematory. Inc. 09-05-12 Beltsville Maryland 22. Name and Address, of Facility S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019												
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has incompletely filled in but the funeral directors.	or, page z	e Completed	25. Was case referred to medical			00 Pl		24a. Was a autops perfor	me d ?		sy findings available inpletion of cause of				
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To the Withir	dinos		29b. Signature and title of certifier	ant	MD	29c. License r	_		e cause(s) and n						
120	\	1	30. Name and address of person who c	on pleted cause of death (It	1 4 — / 1	Fenge H	my A.	neali	Mo	2/0	01				
	State		11. Date filed (Month, Day Year)	32. Registrar's Sign	- A	W.	1 , ,		1.1	0 1 1					
Reg	jistrai		AUG U * 2012	A STATE OF	- The same	-									

12-06645 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Douglas Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 3, 2012 Year Medical Examiner 0334 hrs Douglas Lawrence Wilson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18644 Northaven Street Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min Months Days Hours Director 235-11-4436 1 X M 2 44 Nov. 9, 1967 Country) Maryland Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show Yes 2 X No items 23a or 28a-f shorust be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. Maryland Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18644 Northaven Street 21742 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Married 2 X No Yes X Divorced If Yes, Give Year Specify: White Widowed Yes 2X No specify: event, the Medical Examiner tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/ Operator HVAC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lawrence Albert Wilson Joan Carolyn Devine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) Andrew Wilson 10429 Fish And Game Rd. Waynesboro, PA 17268 20a. Method of Disposition

1 Burial 2 Cremation 3 Baltimore, permit. Pages I and Department of Healt 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Removal from State Hagerstown Crematory important: 9-5-2012 Hagerstown, Maryland Donation 5 Other Sp 22. Name and Address of Facility Osborne Funeral Home P.A. injury Signature of Funeral 425 S. Conococheague St. Williamsport, MD 21795 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Morbid Obesity Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Yes 2 No 3 Probably 4 🗸 Unknown Completed Atter this certificate has been structured director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V No No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Inpatient Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA ဥ 2 Nursing Home 5 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural within 24 hours after death.

To the Funeral Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedleal Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Jack Titus MD.

29d. Date signed (Month, Day, Year)

September 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30031 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8645 AM Dail Alfred Williams edlember 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. Cjty, Town, or Location of Death 4c. County of Death Examiner aureDeGrace If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🛛 M 2 🗆 F Min 03/29/1918 220-03-3961 Director Yrs 94 Usual Residence of Decedent 10b. County death with the Maryland 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Havre de Grace 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Bloomsbury Avenue Funeral U.S.A. 21078 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with. **al Hygiene. **er than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed with and Mental Hygien. 7 is marked other th Contract Specialist Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Alfred Williams Bird Elizabeth Jobes permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 117 Bloomsbury Ave. Havre de Grace, MD 19a. Informant's Name/Relationship (Type, Print) Alice WIlliams (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Forest Hill, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Deerecreek UMC cen 09/08/12 Maryland 22. Name and Address of Facility 123 S. Washington St. Maryland 21. Signa Zellman Funeral Home, P.A. Havre de Grace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a cor Examiner CM Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last urch attending physician and for use as the burial-tran Due to (or as a Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕷 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe Yes 2 Hospital or Attending Physician: The law has 24 hours after death.

Funeral Director: After this certificate 2 🗡 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ျု 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Deat Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Mont)

MN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Elizabeth Louise Weisberg 201 Medical September **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing & Rehabilitation Cen. Berlin Worcester 9. Birthplace (State or Foreign MD Country) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Months Days Min. 9/2671923 **Director** 216 16 1440 88 Usual Residence of Decedent 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sl must be notified MD 1 Yes 2X No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 Healthway Dr. 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married IRG, BETTY L Maryland 21215-0036 1 Yes 2 X No 1 ☐ Yes 2 🔀 No Specify. 3 → Widowed 4 □ Divorced white Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Administrative Assistant real estate company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental Hitem 27 is mar ed of Gloyd MacDonald Anna Louise Zile Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Deutsch (son) 10705 Admirals Lassie Lane, Berlin, MD 21811 Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of 1 Durial 2 X Cremation 3 Removal from State First State Crematory 9/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE Signature of Funeral S 12. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 22. Name and Address of Facility Part . Enter the risk se, or complications that caused to shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical uenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director;

WEISBERG,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Bernal-Clark, 31. Date filed (Month, Day, Year) SEP 0 4

(Check

29b. Signature and title of certifier

FNP-BC, 9715 Healthway Dr, Berlin, MD 21811

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying Nurse Fractioner: To the least of my knowledge seeth secured at the time. Soft and place and due to the cause(s) and manner se stated.

R 131285

29d. Date signed (Month, Day, Year)

September 4, 2012

29c. License number

		For State Registrar	Pleas	State of N		id / Dep	oartme		ealth and		al Hygi	_	112	30033
Physicia Medic			ALLEN W	HITELEY							te of Death onth GUST 2	27, 201	Year 2	3. Time of Death 7:30 A M
Examin	er			give street and number) COURT WES				y, Town, or L STON	ocation of De	eath		4c. County TALE		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. 10/10/10/10/10/10/10/10/10/10/10/10/10/1											9. Birthi Coun	place (State or Foreign htry) MARYLAND
Maryland 28a-f show notified at	Director						own or Location						1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the	Funeral C	10e. Street and Nun 26232 IN		COURT WEST			101. 2	ip Code 2160	1		10	g. Citizen of V USA	What Cour	ntry?
permit. Page 1 and 2 should be flied within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Inmoortant: I fleem 27 is marked other than "naturaly, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 M Yes 2 If Yes, Give Year or Dates.			?	S. 13	If Yes, spe	edent of His ecify Cuban 2 X No	panic Origin? Mexican, Pu Specify:	(Specify Yeserto Rican,	s or No- etc.)		k, White,	
vithin 72 hou giene. er than "natu the Medical	Completed	(Spe Elementary/Sect	5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) EXECUTIVE						6b. Kind of Bo WHOLES. DISTRI				
ild be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (I		st) W WHITELEY						Name (First, IEA MA	Middle, Ma	iden Sumame		
nd 2 shou ealth and m 27 is m ier traum		19a. Informant's Name/Relationship (Type, Print) MARY ANN WHITELEY, WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 26232 INGLETON COURT WEST, EASTON, MD											Code) 21601	
Eage 1 a trent of H tant: If ite jury or oth		20a. Method of Disposition 1 🏋 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOSEPH'S CEMETERY 9/1/2012 CORDOVA, MARYLAN												
permit Depar Impor any in once.		21. Signature of Fu		ensee MERCE	20	$\supset \begin{vmatrix} 1 \\ 2 \end{vmatrix}$	ELLOI 200 S	and Address WS, HE OUTH H	LFENBE	EIN & ON STR	NEWNA	M FUNE EASTON	RAL 1	HOME, P.A. 21601
hysician/ Medical		23a. Part 1. Enter t	he disease, or o rt failure. List or Final	omplications that causely one cause on each li	ed the deather.	th. Do not er		de of dying,	such as card	liac or respi	ratory arres	t,		Approximate Interval Between Onset and Death
Examiner	er	Sequentially list co		b. Due to (of a	1 5	MS	0	DOL	Kin	110-	17 1	ימו (ו		years
cate be executed physician and s the bunal-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
cate be physici s the bu	edical			d										
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?									23d. Date of delivery Month Day Year			
uires that th n signed by ıld be detac														
The law req ate has bee page 2 shou	Completed by									-	4a. Was an autopsy perform	ed?	prior to co death?	opsy findings available ompletion of cause of
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nding Phy ath. : After this e funeral d	icate: To		27. Manner of Death 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 N 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work?							28d. De		oce 6 Other		2
ital or Atter ins after dea al Director led in by th	al Certificate:	3 Suicide 4 Homicide	6 Could n	ot be 28e. Place of li	njury - At h		street, facto	ory, office			ecation (Stre ty or Town,		er or Rura	l Route Number,
the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 only one) 3	Medical Ex	Physician: To the best aminer: On the basis of Nurse Practioner: To the	examination	on and/or inve	estigation, i	n my opinior	, death occurr	red at the tim	ne, date and	place, and du	e to the ca	ause(s) and manner stated
or with		29b. Signature and	title of certifier	11/10	4	100	25	9c. License	14 G	6	29	S/7	d (Month,	Day, Year)
		LUDWI	G/J.ÆG	no completed cause of LSEPER, II	I, MD	50:	3 CYN		ORIVE,	EAST	ON, MI	2160)1	
Stat Registra		31. Date filed (Mont	AUG 3	2012 32.75	rar's Signa	ature /	par	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Physician/ AUGUST 27, 5:15 P ^M ODELL WILSON. SR. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HEALTH & REHABILITATION CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 XM 2 🗆 F Months Days Hours NORTH" CAROLINA apkiii^{h,} 20°, ^Y°1925 244-26-3851 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shor 10a, State death with the Maryland must be notified at Director 1 X Yes 2 □ No WALDORF MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral UNITED STATES 20603 2912 HALIFAX STREET ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?
XYes 2 No Black, White, etc. 1 Never Married 2 Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK If Yes Give 3 ▼ Widowed 4 □ Divorced "natural", Completed Year or Dates Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. 11TH GRADE College (1-4 or 5+) FEDERAL GOVERNMENT LIBRARIAN / CAB DRIVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GERTRUDE BERRY WILSON LAWYER WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar. Important: If item 27 is any Injury or other trau once. W 2912 HALIFAX STREET, WALDORF, MARYLAND 20603 PAMELA WILSON-PRICE/ DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERAN CEMETERY SEPT. 5, 2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 21. Sun ture of Funeral Service Lice s THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 PLYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC HEART DISEASE Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FEEDING DYSFUNCTION autopsy performed? Yes 2 1 No has te 2 page 1 Yes 2 No After this certificate funeral director, pag Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 **X** No 4 Mursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗐 No 2 Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital cal 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier 12 12955 ause of death (Item 23a) (Type, Print) 30. Name and address of person who 2017 FORT WASHINGTON ROAD, FORT WASHINGTON, MARYLAND 20744 M.D POTTER

Registrar
DHMH 17 Rev 7/2009

AUG 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Maryland / Dep	partment of Heal ertificate of Deat		ntal Hygi	ene g. No. 20	12	30035				
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Deat		. Date of Death		1 6-	3. Time of Death				
	Physicia Medic		Thomas Edward Wills	5				4, Day 2012	Year	1:08 p M				
	Examin		4a. Facility Name (if not institution, give str	eet and number)	4b. City, Town, or Locat	tion of Death		4c. County of Death						
			112 Woodland Drive		Indian Hea		0.4. (5).11	Char						
	Funeral Director		5. Social Security Number 6. Sex 1 🔀	M 2 \square F 7. Age (In yrs. last birthday Yrs.	Months Days Hou	urs Min.	Date of Birth (Month, Day,	^(ear)	Count	ace (State or Foreign y) vland				
	ow t		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or I						d. Inside City Limits				
	arylan a-f sh fied a	Director	Maryland Charles	Indian						1X□ Yes 2 □ No				
	the Ma or 28 e noti	Dir	10e. Street and Number	Indian	10f. Zip Code		10	g. Citizen of W	/hat Count	ry?				
	is 23a	Funeral	112 Woodland Drive		20640			U.S.	Α.					
	r death r iterr iner n		11. Marital Status 1 □ Never Married 2 【▼ Married	Armed Forces?	. Was Decedent of Hispanio If Yes, specify Cuban, Me	c Origin? (Specify xican, Puerto Rica	Yes or No- an, etc.)		e - America k, White, e					
939	within 72 hours after death with the Maryland gient trens "natural", or items 23a or 28a-f sho er than "natural", or items 25e notified at the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates.	ecify:		Specify:	pecify: Black						
21215-0036	2 hour	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation e kind of work done during DO NOT use retired)	most of working		6b. Kind of Bu	siness Ind	ustry				
121	ithin 7 ene. r than	Com	Elementary/Seconday (0-12)	of Fd	nty ucation									
d 2	be filed w ental Hygi rked other ic event, f	Be	6 Building Service Manager Board Of I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
ylar	ld be l Menta arked	2	Frank Jordan											
Maryland	2 should I th and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type	State, Zip Code)										
	f Heali item 2		Betty J. Wills 20a. Method of Disposition	20b. Place of Dis		-		d, Md. 20640						
<u>=</u>	Page nent o ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemetery, cr Trinity	ematory or other place)Au Memorial Gar	ig. 29, 2 dens	2012 W	aldorf,	Mar	yland				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeyal Service Li	M00668	22. Name and Address of F Villiams Fune	eral Home	₽. P.A.		4.3 O	0640				
			23a. Part 1. Enter the insease, or complic	ations that caused the death. Do not e	270 Hawthorn ter the mode of dying, such	h as cardiac or re	LIIQLAII espiratory arres	nead, N	10. Z	0640 Approximate				
	Physician/		shock, or heart failure. List only one Immediate Cause frinal disease or condition	wetatati	Small a	ell bu	ing 1	anla	-	Interval Between Onset and Death				
	Medical Examiner		resulting in death)	Due to (or as a consequence of):	44 ()									
		Jer	Sequentially list conditions, b.	Due to for sella noneaquence of:										
	uted id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events											
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of):										
760	physic the bi	edical	d.											
8	certific nding use as	In/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy				23d. Dat	e of delive	ry				
Rox	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Other (specify)			Mor	nth	Day Year				
0	at the d by th	Phy	g ☐ Unknown Part II. Other significant conditions cont		underlying cause given in	Part I.	23e. Did tob	acco use contri	bute to the	e cause of death?				
S, P.	ires th signe Id be o	d by					1 □ Ye	s 2 □ No	3 Prob	ably 4 🗆 Unknown				
ord	aw requas beer 2 shou	plete					24a. Was an		Vere autop	sy findings available				
Ř	The la	Completed					autopsy perform 1 \square Yes 2	ed2 d	eath?					
Vital Records,	ician: certific ector,	Be	25. Was case referred to medical examiner?	spital:	Othor	f Death (Check on								
>	Phys rr this aral dir	e: To	1 ☐ Yes 2 No Po	1 Inpatient 2 ER/Outpat 28a. Date of injury 28b. Time	of 28c, Injury at	Nursing Home 28d		nce 6 COthe						
ono	anding rath. rr: Afte	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work? M 1 ☐ Yes									
Division of	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f.	Location (Stre City or Town,	eet and Numbe State)	r or Rural i	Route Number,				
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical		an: To the best of my knowledge, deat										
	the Hithin 24 the Fi	Mec		r: On the basis of examination and/or inv Practioner: To the best of my knowledge	e, death occurred at the time,	, date and place, a	and due to the o	ause(s) and ma	nn er as sta	ted.				
	F 3 F 8		Alled	L MN	29c. License numb	241	1	d. Date signed	+9.	2012				
	al		30. Name and address of person who con	npleted cause of death (Item 23a) (Type	, Print)	10	11		10	2-4.				
	Stat	e -	31. Date filed (Month, Day, Year)	A. M.E. L. 31. Registrar's Signature	ums	W	aldo	N Or	リ.	10003				
	Registra		31. Date filed (Month, Day, Year) AUG 2 8 2012	Desve B. A.	ares									

nded ite		Decedent's Name (First, Middle, La.	,	1.	Cei	rtificat	e of E	Death	D.H.	2. Date of Do		20	12	3 0 3. Time of 1	
Medic	cal	Stefan Wisnie 4a. Facility Name (if not institution, giv					0.8	2.	Day Year 11:52AM			2AM			
Examin	ier	9824 Barrett				46. City, Ber		Location	of Death			c. County o			
Funeral		Social Security Number 6.	Sex 7. A		ast birthday)	If Unde Months		If Unde	r 24 Hrs. Min.	8. Date of Bi	rth	Vorce		lace (State or	Foreign
Director		092-34-0476 Usual Residence of Decedent	1 ☑ M 2 □ F	91	Yrs.					9%6%1		20 1		" a.Pol	and
yland f sho	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation								0d. Inside City	
e Mar r 28e-	Direc	MD Worce	ester	Ber	rlin	100 7								1 Ves	2 🗌 No
e 1 and 2 should be filed within 72 hours after death with the Maryland for Health and Mental Hygiene. I defined It is merked other then "netural", or iteme 23e or 28e-f show or other treumetic event, the Madical Examiner must be notified at	Funeral Director	9824 Barrett F	Road			10f. Ziş		181	1		10g. C	itizen of W		try?	
death y	Fun	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dece	lent of Hi	ispanic Or	rigin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race			
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hours netura	Completed by	15. Decedent's	Year or Dates. Education		16a. Dece	dent's Usu	al Occupa	ation			16b	Kind of Bus			-
nin 72 ne. fhen "r	e d	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4 or	5+)	life. D	kind of wo O NOT use	e retired)	_		_	1			_ `	
ad within Hygiene.	اما	8 17. Father's Name (First, Middle, Last)			Cons	- LI UC	1			visor		Construction			
2 should be filed th and Mental Hy 27 is merked oth treumetic event	<u>ام</u>	Peter Wisniews								e (First, Middle ca Zab	•	Surname)			
should I and Me is merl		19a. Informant's Name/Relationship (Type, Print)		19b. Mailii	ng Address	Street a	and Numb	er or Rura	al Route Numb	er, City o	r Town, Sta	ate, Zip C	ode)	
and 2 s Health em 27 ther tr	П	Ren Wisniewsk	i-Son	· •				al F	Hwy.	#242,F	Reho	both	,DE	. 199	71
permit. Pege 1 and Department of Hea Mportent: If item any injury or other once.		20a. Method of Disposition 1 Disurial 2 Cremation 3	Removal from State		Place of Dispo cemetery, crer	natory or c	ther plac	e)		Date	20c. Location - City or Town, State 0-12 Willards, MD.				
permit. Pege 1 Department of Importent: If it any injury or o	Н	4 ☐ Donation 5 ☐ Other (Spec		Ne	W HOP	P. Name an	emet	ery:	U8	30-12 rbage	Wil	lard	s, l	4D.	
P a m p a		21. Sign of Fener Arvice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street, Berlin, MD. 21811													
Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										Approximate Interval Betw Onset and De	/een		
ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	immediate Due to (or as a consequence of): Jerlying Jerly												
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ficate g phys es the			d												
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use es the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)										23d. Date of delivery Month Day Year		
ures that I	줍	Part II. Other significant conditions	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death					
has beer ge 2 shou	Completed					_				24a. Was	an ppsy on ned?	pr	ere autopo ior to come ath?	sy findings av	/ailable use of
ral or Attending Physicien: The law requires rs after death. Is Director: After this certificate has been sig		25. Was case referred to medical					OC DI-		-Ab (Ob - a)	1 ∐ Yes	2 Z N		Yes 2	2 No	
yslcie Is cert direct	To Be	examiner?	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 □ Do	Othe		ath <i>(Check</i> lursing Ho	me 5 Resi	idence (6 Other	(Specific)		
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ne Hospi in 24 hou e Funer pletely fil	Medical	(Check 2 L Medical Exam	ysician: To the best of niner: On the basis of e rse Practitioner: To the	examination	and/or invest	igation, in a	ny opinio	n, death o	ccurred at	the time date :	and place	and due t	o the caus	se(s) and many	ner stated.
Not With Control		29b. Signature and title of certifier	al	Jus	$\overline{}$	290	License				29d. Da	te signed (Month, D	ay, Year)	
H 6.		30. Name and address of person who	completed cause of a		23a) (Type, F	Crint)		רכנ	0	Ish	914	ns	0.	502	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Day 02 Physician/ Witkowski Edward A. 2012 06:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hyattsville 6011 85th Ave. If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth (Month, Day, Year) **Director** 120-40-6235 1 XM 2 🗆 F 64 02/19,1948 New York or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If flem 27 is and Mental Hygiene. "Inportant If flem 27 is and the than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Hyattsville Prince Georges 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6011 85th Ave. USA 20784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1968
If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1972 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HVAC **GPO** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward A. Witkowski Jane H. Kazor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Witkowski (Wife) 85th Ave. Hyattsville, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery 09/07/2012 Lewiston, New York 22. Name and Address of Facility Rendon/Hale Funeral Home Signature of Juneral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure: List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ce Physician/ metostati disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Directo (or as a consequence of) Examir ysician and ne burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending phy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ynphono Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 500 erson who completed cause of death (Item 23a) (Type, Print) ldman mo 32 Registrar's Signature State

Registrar

Please Type or Pript in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ rown Month otomber Medical Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Imore N/A Da ohn KINS TOSOI tal If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days Months Min (Month, Day, Year) 214-44-6290 Director 66 Yrs Usual Residence of Decedent 5/4/1946 MD item 27 is merked other then "neturel", or items 23e or 28e-f show other treumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is merked other then "neture!", or items 23e or 28e.f ehm 10a State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Bethune Road 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Dever Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Sweetheart Cup Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Gross permit. Page 1 and 2 should be Department of Health and Ment Importent: If item 27 is merke eny injury or other treumatic o Mary Lee Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Gross-Daughter 2007 E. Lanvale St. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/20/2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Zion Cemetery Mt. 10/2012 Lansdown, MD . Signature of Funeral Service Licenses March F/H-East 22. Name and Address of Facility 1101 Ε. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician va disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No
9 Unknown 3 - Ectopic pregnancy 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 2 🗌 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 W Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature nd title of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 16:10 Derru Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 4115 Century Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 214-88-7157 Director 1 **№** M 2 🗆 F 48 6/26/1964 MD er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A MD 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 4115 Century Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?, 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Walters Art Mus. Tech. Maintenance of Health and Mental Hygie If item 27 is marked other in other traumatic event, <u>tt</u> other Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Vina Berry Leon Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Berry-Wife Baltimore, MD 21206 Century Rd. permit, Page 1 and 2 Department of Healt Important: If item 2 eny injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 9/19/2012 Halethorpe, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, 21. Signature of Funeral Service Licensee MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death rehosis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, making to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 2 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 00 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Mospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DO052553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Rever Blod, Bultimore MD 21239 Lartel J. Naiman, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26.per PHY, g931 9-20-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Buckson Month Richard a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 1210 Valley Street NA Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Ye 08-10-31 Director 250-36-8740 81 1**X**XM 2 □ F SC permit. Page 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mentel Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show with jury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Rockhill SC York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 29730 Apt. 831 Lucas Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. African Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Marýland 21215-0036 1 Yes 2 No Specify: Specify: American 3 ₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade Wayne County Road Road Worker Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Buckson Laura Sims C. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1210 Valley Street Baltimore, Maryland 21202 Garland Gregory-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Grandview Mem. Park 09-24-12 Rockhill, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Wylie Funeral Home P.A. علىه 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Dnset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): tor: After this certificate has been signed by the ettending physicien end the funeral director, page 2 should be deteched for use es the buriel-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No or Attending Physicien: The death? 1 ☐ Yes 2 X No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Daughter's Hospital: Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\overline{\Omega}\) Other (Sp 2 X No 1 🗌 Yes <u>ا</u>و 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation To the Hospital or Atter within 24 hours after des To the Funerel Director completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H006476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Do Karles Carsing Biour Lendin 31. Date filed (Month, Day, Year) SEP 2 0 2012 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

Assistant Medical Examiner

32. Registrary Signature

Carol H. Allan, MD

2012

31. Date filed (Month D

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1f&16a Per FH C932 10/01/2012 JH and Mental Hygions

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Examin	er	4a. Facility Name (if not institution, Upper Chesapea)				4b. City, Town, or Bel	Air		'	40	c. County of I Harf o	ord	
Funeral Director		5. Social Security Number 214–20–0592		7. Age (<i>In yrs. l</i> as		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 12/28	th ly, Year) /192		Country	ice (State or Foreign) lanā
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with th	Funeral Director	109 Darling	ton Road			10f. Zip Code	001_	21078		10g. C	itizen of Wha	t Countr	y?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inpoprament of Health and Mental Hygiene. Inpoprament if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☒ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece	2 XX No	If	Vas Decedent of Hi Yes, specify Cuba	n, Mexicar	n, Puerto R	ify Yes or No- lican, etc.)		14. Race - / Black, V Specify:	Vhite, et	c
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Page ment of ant: If ury or		1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from pecify)	State		Cemetery Cemetery		9/22	/2012			-	ace, MD
permit. Departi Import any inj once.		21. Signature of Funeral Service Li	censee	SOU	22.	Name and Addres	ss of Facili	ity Tari	ring-Ca 21001	argo	Funer	al I	Home, P.A.
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with to the common of the comm		29b. Signature and title of certifier	4	>917		29c. License	e number	356	,8	29d. D	ate signed (N	Nonth, Da	ay, Year) 18 2012
1791		30. Name and address of person v	who completed caus	e of death (Item :	23a) (Type, P	rint) 50	00	Sep.	200	97	Cos	Pa	akg Din
Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu	ure		<u> </u>	Al		71	3HZ	1	
Registra	ar	L SEP 2 0 2	012 /2	COL A.	bar	Kel					-17		

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17, 2012 Therese 5:30 AM Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 072-56-4970 1 M 2 X F 78 June 22,1934 France Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Cormer Court, #101 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 rect Marketing Personnel Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental I 7 is marked of ဥ Devaux Colombe Pepin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 i Elizabeth M. Brown/Daughter 2416 Chetwood Circle, #303, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 9/20/2012 Glen Burnie, Maryland 21. S n to f uner der Bryan W. vice Nice 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Cla Padonia Road, Timonium. W 23a. Part 1. Enter the disease, or complications that can shock, or eart ailure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or resp Approximate Interval Between Onset and Death Immediate Ca. se vinal disease or con illion Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending of for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy this certificate h 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Sp မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident $5 \square$ Pending injury To the Hospital or Attendir within 24 hours after death.
To the Funerel Director: Af completely filled in by the fu r death. 1 ☐ Yes 2 ☐ No Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0071587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shaheen 1070 31. Date filed (Month, Day, Year) State 201

DHMH 17 Rev 06-2011

Registrar

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Registrar

31. Date filed (Month, Day, Year)

SEP 2 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Rita Battista 0640 September 18,2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 193-20-2191 1 🗆 M 2 🕇 F Director 83 12/25/1928 Pennsylvania 28a-f shov 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maruland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 u.s.A. 2 Kerwood Court within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Tom Mosara Mary Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u> Dolores Battista - Daughter</u> 2 Kerwood Court, Silver Spring, Maryland 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 09/20/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fueral Cervice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
T Day Immediate Cause (Final Pnysician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Urinary Tract Infection Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or) and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy e past 12 months? Yes 2 X No in the past 12 Month Day Pregnant at time of death Other (specify) 9 Unknown 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Chronic Renal Failure Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Obstructive Lung Disease 24a. Was an cate has to page 2 s Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 1 Inpatient 2 X ER/Outpatient 3 IDCA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: A pletely filled in by the fu 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12 V

To the P within 2. To the F complete

State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Laura Khandagle,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

D61067

12520 Prosperity Drive, #320, Silver Spring, Maryland 20904

29d. Date signed (Month. Day, Year)

September 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HUSpita)ohn 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral (Month, Day, Year) Days Months Hours Min. **Director** 1 🗆 M 2 🗷 F 31.2010 iNashinatan DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🗆 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 20019 Dlace 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 🗷 Never Married 2 🗆 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nfant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 世 2 Joycelun lliams - mother altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State or other place Burial 2 ☐ Cremation 3 ☐ Removal from State 2/00/2 lenwood 4 Donation 5 Other (Specify) Signature of Funeral Service License 23a. Part 1 Enter the disease, or cor shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10515 disease or condition resulting in death) Medical Due to (r as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an After this certificate has autopsy performed? 1 Yes 2 □ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, is 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 20 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 15, 2012 ELAINE BERGER 12:30 PM 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Min. Months Davs Hours 220-12-8448 1 □ M 2 □X= 04/30/1924 88 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 CHARING COURT 21117 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 ☐XWidowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID **SCHUGAM** RAE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 CHARING COURT, OWINGS MILLS, MD DIANE GENSLER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place) PROGRESSIVE RUDOMER VEREIN CEMETERY 1 X Burial 2 Cremation 3 Removal from State 09/19/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. e of Funeral Service Licen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Interval Between Onset and Death Immediate Cause (Final Dyshagia disease or condition resulting in death) Due to (or as a consequence of): CVA Due to (or as a consequence of): Failure to tros we Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23

Ph sician/ Medical Examiner

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page 2 s has

certificate

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil

that the death certificate be P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician:

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Physician/Medical

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Completed

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Certificate:

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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

an "natural", or items 23a on Medical Examiner must be

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Director

Funeral

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Completed

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Sequentially list conditions. if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical

1 Yes

27. Manner of Death

1 Natural

2 Accider Suicide

24 No

5 Pending

e. Did t	obacco i	use contril	oute to	the cause	e of death?
1 🗆	Yes 2	□ No :	3 🗆 Pro	obably	Onkn

	24a. Was an	2
	autopsy performed?	
	1 Yes 2 No	
'n	ly one)	

24b. Were autopsy findings available prior to completion of cause of death?

l	1	No	1 L Yes	2 📙 N
1/	y one)			
	5 Residence	6 🗆 Ott	ner (Specif	5v)

				.o. i lace o	n Death Tonec	K OHY OHE)
	spital: 1	ER/Outpatient	3 □ DOA	Other:	Nursing H	ome 5 Residence 6 Other (Specify)
l	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.	Injury at work? 1 \(\sum \) Yes	2 🗆 No	28d. Describe how injury occurred

2 Accident	Investigation	M	1 L Yes 2 LINo	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

OCIL	0:	ad title of a wiffing	00 1:	
	only one)	3 Certifying Nurse Practitioner: To the best of my knowled	ge, death occurred at the time, date and place, ar	d due to the cause(s) and manner as stated.
		2 Medical Examiner: On the basis of examination and/or inv		
298	. Certifier	Certifying Physician: To the best of my knowledge, deat	n occurred at the time, date and place, and du	to the cause(s) and manner as stated.

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	SUM	IT !	Bu	UTAN	Ji M	. D .	821	NA

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State Registrar 31. Date filed (Month, Day, Year) 3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SEP 6:20 PM 2012 LAYLA MARIE BARNES Medical 4a. Facility Name (if not institution, give street and number) WALTER REED 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL MILITARY MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours Min. None Director 1 M 2 A F MD SEP 14, 2012 15 54 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland rei", or iteme 23e or 28e-f eho Examiner must be notified at Director 1X Yes 2 ☐ No Fairfax Fort Belvoir 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9219 Soldier Road 22060 United States 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify permit. Page 1 and 2 should be filed within 72 hours eft Department of Health end Mental Hyglene. Important: if item 27 is merked other than "neture!", eny injury or other treumetic event, if a Mulic IE agonce. Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christopher James Barnes Kristen Marie Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9219 Soldier Road, Ft. Belvoir, VA 22060 Christopher J. Barnes / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 09/17/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Se Licensee ²² Name and Address of Facility
Thibadeau Mortuary Service,
7 Park Avenue, Gaithersburg M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ANENCEPHALY Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): e Hospital or Attending Physicien: The law requires that the death certificate be executed 124 hours after death.

Puneral Director: After this certificate has been signed by the ettending physicien end letely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 XNo g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 TrNo 잍 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 1🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0101251953 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER EMILY M MCELVEEN, MD BETHESDA, MD 20889 31. Date filed (Month, Day, Year) . Registrar's Signa State **SEP 20** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Gerald Benjamin Custer 8:40 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8309 Palmer Road Frederick Middletown 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ohio 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (M988/83/1944 291-38-4544 68 Vre Director Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Frederick Middletown 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country must be Funeral items 23a 8309 Palmer Road 21769 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 X Married ≥ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Communication Technician Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Mental Important: If item 27 is marked any injury or out. Claire Custer Virginia Escott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 Palmer Road, Middletown, MD 21769 Karen Dale Custer / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/19/2012 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall (1) Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Interval Between Onset and Death Immediate Cause (Final Metastatic Angiosarcoma Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Examir -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy 2 2 No 1 Yes 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Tes 2 2 No ရု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\sum \) Nursing Home 5 Residence 6 Other (Specify, hours after death. meral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сопрете (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ordress of person who com cause of death (Item 23a) (Type, Print) Eskander 501

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Grafton G. Dietz, Sr. 12:15p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 15813 Old Frederick Road Woodbine Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1X M 2 □ F <u>212-30-2907</u> Nov. 20,1933 Maryland 78 is then "natural", or items 23s or 28e-f show the Modicel Examiner must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Merylend Director 1 Yes 2 XNo MD Woodbine Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 15813 Old Frederick Road 21797 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1X Yes 2 No
If Yes, Give
Year or Dates. 1952–56 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Commercial t. Pege 1 and 2 should be filed with transit of Heelth and Mantel Hygler rtent: If Item 27 is merked other 1 jury or other traumetic event, ID Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Elizabeth Bleach George Grafton Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Dietz / wife 15813 Old Frederick Rd. Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Depertment o Importent: If eny Injury or Final Journey Crematory 9/13/12 Woodbine, MD 21. Signature of Ameral Service Licensee 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Heckrotte, P.A. Clarksville, Beverly L. MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mesothelioma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir or Attending Physicien: The lew requires thet the death certificete be executed Cause (Disease or injuly that initiated events for use es the burlal-trer resulting in death) Last Due to (or as a consequence of): ettending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) deteched cate has been signed by pege 2 should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia, ASAD 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 5 No Yes 2 No 1 Tes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospitel o within 24 hours af To the Funerel DI Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗆 Certifying Hurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of ertifier 29d. Date signed (Month, Day, Year) 030573 9-13-12

Registrar
DHMH 17 Rev 06-2011

State

10710 Charter Drive Suite GO20 Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Jon Minford 1
Date filed (Month, Day, Year)
SEP 2 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	ryland		artment of F <i>rtificate of</i>		nd Menta	ıl Hygiei Reg.	1116	30052
	Physici	an		e (First, Middle, La:	st)					2. Date	e of Death	Day Yea	3. Time of Death
	/Medic	al		Bernard D						Sep	t. 15,	2012	11:30 A M
	Examin	er	Bedford	_	street and number)			4b. City, Town, o	r Sprin			4c. County of De Montgom	
H	Funeral		5. Social Security N		ex 7. Age	(In yrs. las	st birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date	e of Birth		cirthplace (State or Foreign Country)
	Director		723-10-2	804	© M 2□F	90	Yrs.	Months Days	Hours	Min. Jun	nth, Day, Ye e 26, 1	922 Ca	nada
	and w		Usual Residence of 10a. State	f Decedent 10b. County		10c. City.	Town or Lo	ocation					10d. Inside City Limits
	Maryl f sho	ō	MD	Montgome	rv			Spring					1 ☐ Yes 2 € No
	r 28e	Director	10e. Street and Nu		2			10f. Zip Code			10g.	Citizen of What	Country?
	deeth with the Maryland ms 23a or 28e-f show		15311 B	eaverbroo	k Court Ap	t 1C		2090	6			USA	
	tams	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of H	lispanic Originan, Mexican, I	n? (Specify Ye Puerto Rican, e	s or No-	14. Race - Ar Black, Wi	nerican Indian,
30	rs afte	by Fi	1 Never Marr 3 X Widowed	ied 2 Married	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2X No	Specify:			Specify.Wh	
2-003p	within 72 hours after ene. than "naturel", or Ita ne Macical Examins	ted t		15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occup	pation		16b	. Kind of Busines	
7	thin 7.	Completed	(Spec	ondary (0-12)	de completed) College (1-4or 5-	+)	(Give life.	kind of work done DO NOT use retire	during most o d)	of working			,
N	e filed wi al Hygien other th vent, the	Con			4		Super	visor				ilroad	
and	i be fi ntal H ed otl	Be	Eudore I	(First, Middle, Last) Drumac						s Name <i>(First,</i>		len Sumame)	
Ž	2 should be f and Mental h Is marked of reumatic eve	은		ame/Relationship (Type, Print)		19b Maili	ng Address (Street		Lagueux		v or Town State	Zin Code
N N	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23a or 28e-f show other treumatic event, the Medical Examinar must be multilad at				ult / frie	nd		Crain H				715	, 2.0 0000)
e,	of Hee		20a. Method of Dis	position		20b. Plac	ce of Dispo	sition (Name of matory or other plan		Date		Location - City	or Town, State
Ĕ	Page ment ent: If ury or			Cremation 3 ∟ 5 ☐ Other (Specify	Removal from State /)		-	rney Cre	·	9/20/1	2 Wc	odbine,	MD
Бащто	permit. Pages 'Depertment of Himportent: If Ite any Injury or of once.		21. Signature of 5	neral Service Licer		M0165	1	2. Name and Addre	ss of Facility Crema	ation S	ervice	P.O. B	ox 784
	10000		23a. Part1. Enter t	the disease, or com	plications that caused	the death.	L	ter the mode of dyir	 Hecking, such as ca 	rotte, ardiac or respir	P.A. Catory arrest,	larksvi.	11e, MD 21029 Approximate
	Physician		Immediate Cause disease or condition	(Final	one cause on each lin	e.	~ ti	no sh	cole-				Interval Between Onset and Death
	/Medical		resulting in death)		a. Due to (o as a	a conse ue		10 210	OKC				
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5	ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as a	conseque	nce of):						
m	xecut and al-tran	xan	that initiated events resulting in death)	S	cDue to (or as a	a conseque	nce of):						
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מכא	th cer tendir ir use	hysician/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome of	of pregnance	y leath 3	DEctopic pregnance	,			23d. Date of c	,
5	ne dea the at hed fo	sici	in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	□No	4☐Pregnant at t 9☐ Unknown			Other (specify)	<u>'</u>			Month	Day Year
ŗ	that the ed by detac	₾.			ontributing to death bu	ıt not resulti	ina in the u	nderlying cause gry	en in Part I	230	e. Did tobaco	o use contribute	to the cause of death?
Š	uires sign ld be	d by	· ·		3								Probably 4 Unknown
ecorus,	s beer shou	Completed								24:	a. Was an		autopsy findings available
C	The la	ошь								_	autopsy performed	? prior t	o completion of cause of
	:len: artifice ctor, p	Bec	25. Was case refer examiner?	rred to medical					26. Place o	of Death (Check	Yes 2 k only one)	No 1 Y	98 22 140
> 5	hysic this ce	To	1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpatier		R/Outpatier		er: 42Nurs	ing Home 5[Residence	6 □Other (S)	pecify)
	Ilng P	lon:	27. Manner of Deat 1 Natural	5 Pending	28a. Date of Injun (Month, Day	Year) 2	8b. Time o Injury	Wor		1	scribe how in	njury occurred	
VISION	death death ctor: y the	ertification;	2 Accident 3 Suicide	investigation		ırv - At hom	e farm sti	M 1 □	Yes 2 □ No	-	ation (Street	and Number or	Rural Route Number,
2	after after I Dire	ertii	4 Homicide	determined	building, etc	(Specify)	o, iaiii, 30	eet, factory, office			or Town, St		nurar noute Number,
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a:	edical C	29a. Certifier (Check only	t Certifying Ph 2 ☐ Medical Exan	ysician: To the best on the basis of	examinatio	edge, deat	h occurred at the tir vestigation, in my o	me, date and prinion, death	place, and due	to the cause e time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	o the ithin 2 o the omplei	Med	one) 29b. Signature and		and manner stat	ted.		29c. Licens				Date signed (Mo	
	r ≼ ⊢ ŏ		•	Re	25			į.	5456	66	1 .	16/12	,,,
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	Sta	te.	31. Date filed (Mon	nth, Day, Year)	32. Registra	r's Signatur	Creo 1	gio Arn	w#1-	175,6	recto	ring, mr	20902.
	Registr		SEP	2 0 2012	Geneval 1	1. 4	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:32 №M September Catherine R. **DeVilbiss** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1106 Camberley Ct. Harford Abingdon Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 218-09-3185 Director 1 🗆 M 2 🗓 🗶 Jan. 19, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f Maryland 1 Yes XX No Harford Abingdon ь 10e. Street and Number 10g. Citizen of What Country? items 23a 21009 USA 1106 Camberley Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X XWidowed 4 □ Divorced SpecifWhite Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SEPTEMBER Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 18. Mother's Name *(First, Middle, Maiden Surname)* Julia Unknown 17. Father's Name (First, Middle, Last) Frank Kaczmarek 19a. Informant's Name/Relationship (Type, Print)

Valerie Brenner/Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1106\ \mathtt{Camberley}\ \mathtt{Court}\ \mathtt{Abingdon}\ \mathtt{MD}\ 21009$ 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9/22/12 Baltimore Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service, Licenses Leonard Address of Ruck, Inc. 5305 Harford Road Baltimore MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury burial-tran DEVIL BISS that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) 4 Pregnant : 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signormpletely filled in by the funeral director, page 2 should the funeral director, page 2 should be seen as the funeral director. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural Accident iniury 5 Pending work'? 1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

SEP 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 950 A M 1. Decedent's Name (First, Middle, Last) Physician/ Thomas Richard Dmytrow Medical 4c. County of Death 4a. Fagility Name (if not institution, give street and number, **Examiner** more 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Pay, Year) Country) Maryland Days 1 X M 2 □ F 82 213-28-3211 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 □ No Towson **Baltimore** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21286 523 Sussex Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. Š 1 X Never Married 2 Married X Yes Yes, Give 2 Army Maryland 21215-0036 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) ဂ Mamie Thomas Dmytrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3700 Greenspring Avenue, Apt. 604, Baltimore, MD 21211 Phyllis Pilcher / Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State 9/19/2012 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Signature of Funeral Service Licenses Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner exaces Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying MMO the burial-transit Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Completed by Physician/Medical Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown Νo 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** filled in by the funeral director, Be Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: After Hospital or Attending 1 🔀 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License numbe Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

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Richard

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ellwood Brenda Joy September 4:26 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Hospital of Cecil County **Elkton** Cecil If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Months Hours Min (Month, Day, Year) **Director** 224-72-4389 1 M 2 X F 62 11/25/1949 Virginia Usual Residence of Decedent 28a-f shov 10a, State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Cecil Chesapeake City 10e. Street and Number F 10g. Citizen of What Country? by Funeral 23a with 100 Grayson Avenue, Apt. 101 21915 U.S.A. and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. oľ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify If Yes Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ဂ Norman E. Kirk, Elizabeth Jessie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MDitem 27 William R. Ellwood / Spouse 100 Grayson Avenue, Apt. 101, Chesapeake City, 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 09/18/2012 Hanover, Maryland 21. Signature of Funeral Service 1 - ee Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_{sician} Sepsis Medical resulting in death) Examiner 4 days Preumonto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD, CHF 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy perform the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 **N**0 ည 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after use....
To the Funeral Director: After th 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed

31. Date filed (Month, Day, Year) SEP 2 0 2012

se of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Cecil Count

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Frank Anthony Emanuele. September 2012 0850 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montgomeru 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Days 577-18-3495 Director 1 X M 2 D F 88 June 13.1924 Washington.DC filed within 72 hours consider Hygiene.
ed other than "neturel" or items 23e or 28e-f show
es other, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12406 Venice Place 20904 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ٥ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Laundry & Dry Cleaning College (1-4 or 5+) Founder/Owner Sиррви Сотрапи 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file. h end Mentel F 7 is marked of Vincent Emanuele Filomena DiCosmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pege 1 and 2 st ment of Health e tant: If itsm 27 is Angelina Emanuele - Spouse 12406 Venice Place, Silver Spring, Maryland 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗓 Other (Specify) Entombment 09/24/2012 | Silver Spring, Maryland Gate of Heaven Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO7 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypercarbia ase or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): buriel-trensi Physician: The lew requires thet the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as the attending E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months? Day 1 Yes 2 No the g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Congestive Heart Failure Completed 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available Diabetes autopsy performed?

1 Yes 2 X No prior to completion of cause of death? this certificete Hupertension 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPice 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t 28d. Describe how injury occurred Hospitai or Attending 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours effer death.

To the Funerel Director: Aft completely filled in by the fur Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

DHMH 17 Rev 06-2011

CRNP

Debrah Miller.

31. Date filed (Month, Day, Year)

6001 Muncaster Mill Road, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:04 7 Donald Freaner 09/16/2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Washington 4b. City, Town, or Location of Death **Examiner** Smithsburg 13423 Rowe Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral Director** 218-22-2535 1 XM 2 TE 04/15/1929 Maryland 83 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at with the Maryland Funeral Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Washington MD Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A. 13423 Rowe Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status ıral", or iten Examiner r Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than 'other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even မ Vincent Eleanor Helen Beercloth Freaner George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13423 Rowe Road, Smithsburg, MD 21783 <u>Patricia Freaner</u> / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗋 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 09/19/2012 | Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Sico 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phulician! CARDIOMYOPATH disease or condition 6 DAYS Medical resulting in death) Due to (or as a conse dence of): **Examiner** YOCAROIAL Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Concovary Antery Distast Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events attending physician and resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC RENAR FAICURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\sum \) Yes \(2 \sum \) No

the Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 should ate has bage 2 s

Completed Certificate: To Be Medical

after death.

| Director: After this certificate | filled in by the funeral director, within 24 hours a To the Funeral D

CEREBRAL INFANCTION 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\sigma}\) Residence 6 \(\sum \) Other (Specify) 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0051395 Man

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21742

Registrar

29a. Certifier

1110 MEDICA CAMPIS ZD. SUITE 107, 32. Registra Signa

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 4.44 AM Samuel Floyd 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Good Samaritan Rospital Baltimore Birthpie... Country) MD 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sęx 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. 4 /87 19 25 219-16-6298 **Director** Usual Residence of Decedent a or 28a-f show be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 X Yes 2 ☐ No N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 1050 E. 33rd St. #316 21218 USA permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 X Yes 2 □
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Postal 12th N/ACarri Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Floyd Elizabeth Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Floyd-Wife #316 Baltimore, MD 21218 1050 E. 33rd St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/26/2012 OwingsMills, Garrison Forest 22. Name and Address of acility March F/H-East 21. Signat A of Funeral Service Licensee E. North Ave. Baltimore, MD 21202 1101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Negative disease or condition resulting in death) mon Medical Due to (or as a cons rivence of): ndion Examiner Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Kiche Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day in the past 12 months? 4 Pregnant : 9 Unknown Pregnant at time of death 2 🗌 No Yes 1 ☐ Yes 2 L 9 ☐ Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 🗆 Yes 2 🗆 No 21 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 မ 1 Impatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation n 24 hours after death le Funeral Director: / oleted filled in by the f Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one

State Registrar 29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

shrikant Tamhane, MD

KID

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

000

Good Samaritan Kogstal, Lach Raven Blvd Bultimore, MD 2/239
fistral Signature

29d. Date signed (Month, Day, Year)

09/17/2012

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(3+1)		30. Name and address of person	an who completed cause	of death (Iter	m 23a)						, , ,		
		Ana Rubio M.D., Ph.			miner 900	W. Balti	imore	Street,	Baltim	ore, MD 2	1223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IVY HALL GERIATRIC & REHAB MIDDLE RIVER BALTIMORE Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Hours 220-24-7685 1 XM 2 □ F 83 03/06/1929 Usual Residence of Decedent MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 🗌 Yes 2X No MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 SUE GROVE ROAD 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. 1948—52 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 XDivorced WHITE Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRONICS TESTER MARTIN MARIETTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE MICHAEL THEODORA FLURY NOSEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA ANN COLE/DAUGHTER 1839 CALAHAN AVENUE, NORTHPORT, FL. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SACRED HEART OF 4 ☐ Donation 5 ☐ Other (Specify) JESUS 9/21/ 2 BALTIMORE, MD Signature of Fundamental Provice Licensee Name and Address 700 S. & CONKLING 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

requires that the death certificate be Division of Vital Records, P.O. Box 68760 þ the Hospital or Attending Physician: The law ithin 24 hours after death. The Funeral Director. After this certificate has the Funeral Director. After this certificate has tmpletely filled in by the funeral director, page 2 s.

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Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

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		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								
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3 Defitifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ GRAVES WARNICK SHERMAN CEPTEMBER 182091 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVEN 8. Date of Birth (Month, Day, Year) 06-17-1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 № M 2 🗆 F Months Hours 88 226-20-698 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Numbe Funeral 6190 Radecke AVENUE 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE RUCK DRIVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VICTORIA GRAVES permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) berta Nettie Graves BAUTIMORE, Md. 21206 /WIEE Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State BALTIMORE, Md GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUSHN GREENS FUNERAL SWS . Signature of Funeral Service Licensee 3 York Good. BATIMORE, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ COLON Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ပု 1 Yes completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural iniurv 5 Pending after death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1/D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BOULEVARD BATTMORE, MD. 7,218 State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of D			Reg. No.	30062	
	Physicia	n/	1. Decedent's Name (First, Middle, La.	ilgene	GRIGO			2. Date of Dea	Day	3. Time of Death	
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П	Funeral		5. Social Security Number 6. S	ex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)	
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	land shov	ţċ	10a. State 10b. County	100	. City, Town or Loc	ation				10d. Inside City Limits	
	a Mary	Director	MD Howard		Columbia				10.000	1 ☒ Yes 2 ☐ No	
	vith th		5495 Cedar Lane,	#412		10f. Zip Code 21044			10g. Citizen of \U.S.A		
	tems terms	Funeral	11. Marital Status	12. Was Decedent Ever i	n U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Rac	ce - American Indian,	
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Baltimore, Maryland 21215-0036	parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show early fujury or other traumatic event, the Maches Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other place	e)	Date		- City or Town, State , Maryland	
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			1 - State Registrar Certificate of Death Reg. No. 201									30063	
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	To the H within 24 To the F complete		only one) 3 Certifying Nurse Prac	titioner: To the best of m	y knowledge,	death occurred at	the time, date	and place, and	d due to the c	ause(s) and m	nanner as st	ated.	
	6 ₩ 60		29b. Signature and title of certifier M. (he his	h		29c. Licens	7 2 7 4	\$7	290	I. Date signed	(Month, D	ay, Year)	
	4		30. Name and address of person who complet	ed cause of death (Item	23a) (Type Pr	rint)				1110	114	•	
	4		Dr. mahamad	hehab	9000	Frankli	n Squa	are do	ive Br	altim	ose. A	10 21237	
	Stat		51. Date filed (Month, Day, rear)	32. Registrar's Signal	ure		,-,-				, - / .		
	Registra	ır	SEP 20 2012 Jene	W. 19.									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rankin Gilliss September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blakehurst Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Hours Director 217-12-4371 1 M 2 V F 88 9. 1924 Sept. New York permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified any once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 W. Joppa Road 21204 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School 5 Teacher Education years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Samue1 Edith Reilein Fergusson Rankin Mav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 W. Pennsylvania Ave. Suite 600, Towson, MD 21204 Edward J. Gilliss (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-20-12 Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility itchell-Wiedefeld Funeral Home, Inc 5500 York Road Baltimore, Marylanc 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ month disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Funeral Director: After this letely filled in by the funeral of 27. Manner of Death 1 Natural 2 Accident 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certif

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) SEP 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30065 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 ICHAR Year AGHAGEN .35AM 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4h City Town or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Aug 6, Day 1944 462-68-0485 Director 68 Texas 1 🔀 M 2 🗆 F Usual Residence of Deceden 28a-f show 10a. State the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Laurel 1 Yes 2 X No 10e. Street and Number F 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 3364 Old Line Avenue 20724 USA "natural", or items death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married Black, White, etc. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Para-Mutuel Teller nd Mental Hygier marked other t Horse Racing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Myles Wentzel Gaghagen Eleanor May Shuey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Diana T. Hamm/Executor P.O. Box 715 Laurel, MD 20725 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/20/12 4 Donation 5 Other (Specify) Woodbine, MD re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ DENOCARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 3 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of eral Director: After tilled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending after death. Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) 29b. Signatue and title of certifier 29c. License number 28595 MM

State

DHMH 17 Rev 06-2011

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Registrar SFP 2.0.2

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31. Date filed (Month, Day, Year)

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POBOX 1525 DWINGS MILL MD21117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death acres Physician/ 12:50 A M 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rowen N/A Baltimore -och CLC Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F (Month, Day, Maryland Months Hours Min. Director 215-01-2667 Oct 92 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Baltimore Sparrows Point 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 USA 7823 Denton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Specify: 3 X Widowed 4 Divorced White Completed Year or Dates. 1944–46 Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Union Local 29 Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Acree Frances Chaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Joy Craig (Daughter) 7823 I Denton Avenue, Sparrows Point, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: I Meadowridge Memorial Park 9/20/2012 Elkridge, Maryland 4 Donation 5 Other (Specify) . Signature o Jun ral Se vice Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker MOO175 3204 Mountain Road, Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onsel and Death Immediate Cause (Final Physician disease or condition resulting in death) menlia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? igned by the atte be detached for Month Day 5 Other (specify) Pregnant at time of death 4 Pregnant 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 1 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy has yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔯 No 1 Yes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Many er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural Accident 5 Pending work s after death. 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevard, Baltimore, Maryland 21218

State Registrar

DHMH 17 Rev 7/2009

John S

31. Date filed (Month, Day, Year)

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3900 Loch Raven

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year SANIYA MARIE GRAYS 08 2012 08:08 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 1 □ M 2 🕱 F 08/12/201 10b County 10c. City, Town or Location 10d. Inside City Limits N/A 1 X Yes 2 No Baltimore CITY 10e. Street and Numbe 10g. Citizen of What Country? Sunmar 21207 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 ▼No Specify 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KENNETH GRAYS Tiashia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIASHIA ESTREET/MOTHER 100 SUNMAR COURT, APT. 2C, BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State BAYVIEW CREMATORY 9/11/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of ervice Licenses 22. Name and Address of Facility 1961 EASTERNE AVENGE, BALTO: , MBOME 1231

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

MD

100

Examiner

Funeral Director

28a-f show

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be a once.

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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requires that the death certificate be executed

To the Hospital or Attending Physician: The law

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Division of Vital Records, P.O. Box 68760

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lical Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any having to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory Distress Syndrome Due to (or as a consequence of): b. Extreme Prematurity C. Due to (or as a consequence of): d. Due to (or as a consequence of):	Approximate Interval Between Onset and Death 2 weeks 2 weeks						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Part II. Other significant conditions of	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown ontributing to death but not resulting in the underlying cause given in Part I.		livery Day Year the cause of death?					
Completed		24b. Were au	robably 4 Junknown topsy findings available completion of cause of						
Be	25. Was case referred to medical examiner?	26. Place of Death (Check on	ly one)						
ပ	T L Yes 2 M No	Hospital: 1 Yes 2 No Hospital: 1 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other							
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	y occurred						
al Certi	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	nd Number or Ru s)	ral Route Number,					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									

29c. License number

D047221

29d. Date signed (Month. Day. Year)

2012

21204

August 28,

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year CALVIN HICKS 9 2012 2:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Samaritan HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 🗆 Hours Min. 227-20-7699 87 **Director** -12-1925 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1040 E. 33rd Street USA 21218 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.

Specify: AFRICAN þ 1 Never Married 2 Married 1 ★ Yes 2 □ No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF-EMPLOYED HAULER Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ELIJAH HICKS PERLINE LACY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10608 HEATERLEGH DR. CHELTENHAM, MD. 20623 MARILYN HICKS INIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/12 GARRISON FOREST BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCVS 0 4905 YORK BAUTIMORE, Md. 21212 Koad. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Intracellular Bleeding disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension
Lycolorus a consequence offi Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Discase, Congestive Heart Failure, Chronic Obstructive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pulmonary Disorder, Atrial Fibrillation, Aleheimer's Dementia autopsy performed this certificate has 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examine?
1 Yes 2 No Hospita Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Baltimore, Maryland 21215-0036

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EllenTsai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samaritan

Registrar DHMH 17 Rev 7/2009 29c. License number

Hospital of Maryland

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Maryland 21215-0036	bue sum		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street a	and Numb	er or Rura	l Route Numbe	er, City	or Town, Sta	te, Zip Cod	te)
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: If them 27 is marked other then "neture!", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Evaruiner must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		quare	emetery, crem atomy Gi				00/1	8/2012	l ua	nover	Mars	brelv
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			shock, or heart failure. List only	one cause on ea	e cause on each line								Jn	pproximate hterval Between Inset and Death	
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Mary and Mary	Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):								/	
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30	deeti e ett ed fo	sici	1 ☐ Yes 2 ☐ No	4 ☐ Preg 9 ☐ Unkı	nant at time of	death 5	Other (se	pecify)					Mont	th Da	ay Year
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Ö	deat deat ctor: y the	tific	2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	be 280 Place	of Injury - At ho	ome farm etr			ies z L		28f. Location (Ctmat a	and Mumbar	or Primi Po	outo Mimbor
>	or A after Direction by	Cer	4 Homicide determine		ing, etc. (Specif)		eer, lactor	y, onice			City or To			Or noral no	oate Namber,
	To the Hospital or Attending Physician: The lew requires that the dee within 24 hours after death. To the Funeral Directors After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical Certificate:	29a. Certifier 1- Certifying Pt	weicien: To the b	act of my bases	ladae doath	One insert -	at the time	o doto ac-	1 place	nd duo to the -	20122/2	and man-	r ge statad	
	Fun Fun stely	edic	(Check 2 L Medical Exa	miner: On the bas	sis of examination	n and/or inves	tigation, in	my opinio	on, death o	ccurred at	the time, date	and plac	ce, and due t	to the cause	e(s) and manner stated
:	thing the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	Ž	only one) 3 Certifying No. 29b. Signature and title of certifie	ırse Practitioner	r: To the best of r	ny knowledge		curred at t		ate and pla	ace, and due to				
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	1		7/00.00		OFN)	- 1 -	70		07	100	nye	-1/1012
	()		30. Name and address of person wh	completed caus	se of death (Item	n 23a) (Type, F	Print)		1	/	1		1,	4.	
			MILCHAEL - 1	-ac iv	112 m	44	SVE,	ten	selt	14	MINNA	4/10	1415	2140	/
	Sta		SEP 20 2012	acres 32. A	legistraes Signa	and	/								
	Registra	II.		,	1 17	1000									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 Gloria W. Hansen September 13, 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Genesis Layhill Center Montgomery Social Security Number If Under 1 Year **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Davs Feb 2, 1927 Hours Min. Director 85 Iowa 480-30-5518 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Funeral Director must be notified 28a-f 1X Yes 2 No DC Washington, D.C. 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a 700 7th Street SW #329 20024 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: White 3 Widowed 4 Divorced Year or Dates Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Home Economics Promoter Cannery Association Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Chris Hansen (unk) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Rodney Hansen/nephew 27500 NE 350th Street Yacolt, WA 98675 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/15/12 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service Signature of Funeral Service Lice P.O. Box 784 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death -h, sician/ End stage Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Dav Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and the of 29c. License number 29d. Date signed (Month, Day, Year) September 13, 2012 D64208

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

32. Register's Signature

3227 Bel Pre Rd Silver Spring, MD 20905

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saadia Husain, M.D.

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 16, 2012 Francisca G. Hernandez 2255 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 577-13-0938 Director 1 □ M 2 💢 F 38 April 03.1974 El Salvador Usual Residence of Decedent 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomeru Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2700 Barker Street 20902 U.S.A. hours after death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1

Yes 2 □ No Specify: 3 Widowed 4 X Divorced Specify. Completed Salvadorian White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) WASA Customer Service Rep. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ismael Hernandez Ana L. Bermudez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 1404 Euclid Street, NW, #8, Washington, DC 20009 Loren Redman - Daughter Baltimore, If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 09/22/2012 | Silver Spring, MD 21. Signature of Funeral Service Licenset 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ Severe Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed ause (Discase Of Injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anoxic Encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 performed?

1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 X No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation filled in by the within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of D63579 September 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Maria Tayag, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ Mary Melinda Holley 09 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson
If Under 1 Year If Under 24 Hrs.
Hours Min. **Baltimore** Gilchrist Hospice Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours Director 218-48-3974 1 □ M 2 🔀 F 65 1946 13. Maryland Usual Residence of Decede ed other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 🖳 Yes 2 🗆 No N/A Maryland Baltimore 5 4 1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1532 Boyle Street 21230 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ☐xWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other then " Elementary/Secondary (0-12) College (1-4 or 5+) Secretary N/A Legal Services Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl A. Baer Myrtle M. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Wilson (Executor) Periwinkle Place Martinsburg, West Virginia 25403 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Removal from State Glen Haven Mem. Park !09-21**-**2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P 130 E. Fort Avenue Baltimore, Md M00-73223a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ a. Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Erret Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician end I for use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a ld be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? ᅌ Division of Vital Records, BREAST CANCOR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has 2 1 No After this certificate funeral director, pag 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No |요 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) iours after death.

neral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Day filed (Month, Day, Year)

SEP 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 4a-b, 23a, per phy, 8931 9-20-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 15 Physician/ SEPT. 10:55 2012 HOCKSTEIN ALFRED Medical 4a. Facility Name (if not institution, give s 4c. County of Death give street and number) est Drive, #323 Examiner HOWARD Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min Director 143-14-7416 1 **X** M 2 □ F Yrs 06/18/1923 NJ89 Usual Residence of Decedent 10d. Inside City Limits aţ 10a. State 10b. County 10c, City, Town or Location Director Examiner must be notified 28a-f 1 Yes 2 X No ELLICOTT CITY HOWARD MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ò 23a Funeral USA 21043 3315 OAK WEST DRIVE, #323 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin 1 Never Married 2 X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) WESTINGHOUSE ENGINEER 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental F item 27 is marked of ဂ္ဂ RIET HOCKSTEIN FAYE UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 OAK WEST DRIVE, #323, ELLICOTT CITY, MD 21043 DORIS HOCKSTEIN/WIFE other item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1
Department of I
Important: If it
any injury or or
once. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State BETH ISRAEL MEM. PK. 09/19/2012 WOODBRIDGE, NJ 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service of nse 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause each line. **Clioblastom**: Immediate Cause (Final - DAY Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner GLIGBLASTO M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death for Month Day Year Pregnant at time of death should be detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' Yes 2 No 1 Yes 2 No ours after death.

eral Director; After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital 1 Yes Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) injury 1 Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

121

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 20

LITTLE

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATMXENT

PKNY

DHMH 17 Rev 06-2011

SUITE III

29c. License number

D50404

COLUMBIA

29d. Date signed (Month, Day, Year)

17.

2012

SEPT.

21044

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death september 16, 2012 Physician/ 7:00 A M Joyce Louise Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 2002 Calvary Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Months Days Hours Director 215-42-5189 1 □ M 2 🔀 F 68 1944 Maryland 14. 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location Director 1 ☐ Yes 2 🔀 No Harford Bel Air Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21015 USA 2002 Calvary Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lincoln Gullion Annie Irene Tibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Calvary Road, Bel Air, MD 21015 Pauline Johnson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 9-19-12 4 ☐ Donation 5 ☐ Other (Specify) Dublin Miss. Bap. Cem Darlington, Maryland 21. Signature of Puneral/Service License 22 Name and Address of Facility McComas Funeral Home 50 W. Broadway, Bel 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ breat concer metastatic month disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
5 Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and detached for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? completely filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17,2012 D40850 dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

MD

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32. Registrar's Signature

Franklin Synan Dy

Bulhmin

MD 21237

	1 - State Registrar		Cei	rtificate of	Death	1	Reg. No	201	2 300		
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dical niner		·		4b. City, Town,	or Location of Deat	•		. County of			
al	5. Social Security Number 6.	of Bultimore Sex 7. Age (In yrs. las	t birthday)	If Under 1 Yea				9	Birthplace (State or For		
or	231 - 60 - 5002 Usual Residence of Decedent	1 X M 2 □ F 6 4	Yrs.	Months Day	B Hours Min	(Month, Day 0 4 / 0 8		48 V	Country) irginia		
To Be Completed by Funeral Director	144			Town or Location					10d. Inside City Lin		
Director	Maryland 10e. Street and Number	Bal	timo	re 10f. Zip Code			10- 0	tizen of Wha	1 🔀 Yes 2		
Funeral	5218 Linden He	eights Avenue		21215			US.		at Country?		
	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- o Rican, etc.)			American Indian, White, etc.		
od be		1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		1 □ Yes 2 🔀 N	lo Specify:			Specify: B	· ·		
Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occ kind of work don	rking	16b. F	(ind of Busir	ness/Industry			
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To Be	17. Father's Name (First, Middle, Last)				1	me (First, Middle,	Maiden	Surname)			
-	Thomas E.Jeffe 19a. Informant's Name/Relationship (10b Maili	Inez Johnson Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23236							
	Sarah J.Archer		8661	Woodw	ard Driv	re North	n C .	heste	erfield,Va		
	20a. Method of Disposition 1X Burial 2 Cremation 3		ace of Dispo metery, crei	osition (Name of matory or other p	ace) 9/2	2.2712	20c. L	ocation - Ci	ty or Town, State		
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once	when the	44							Funeral Ho		
	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only								Approximate Interval Between		
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xaminer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to or as a conseque	nce off:								
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sician/I									ite to the cause of death		
Physician/Medical		contributing to death but not resul									
Ş	Part II. Other significant conditions	contributing to death but not resul	ining in the t	andenying cause	given in Fart i.	1 🗆 ነ	es 2	□ No 3	Probably 4 Unkr		
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State Registrar W Belvedere

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401

32. Registrar's Signature

J. Hansen

SEP 2 0 2012

31. Date filed (Month, Day, Year)

059062

Baltimore

13,

21215

MA

2012

12-07001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

harles A. Johnson	1- For State Registrar	ite of Maryland / De C	Certificate of De		Reg. I	No. 201	2 3007
Physician/ Medical Examiner	1. Decedent's Name (First, Middle	,Last) Charles A. Jo	hnson		Date of Death Month Da September 1	ay Year 6, 2012	3. Time of Death 1859 hrs
wedical Examiner	4a. Facility Name (if not institution St, Joseph Hospital		4b. Cit	y, Town, or Location of Deat		4c. County of Death Baltimore Cou	
Funeral Director	214-86-5300			nder 1 Year If Under 24H nths Days Hours Mi		MM/DD/YYYY) 9. Bir 1962 Foreig Co	thplace (State or in unityary land
and shaw any nce. Or	Usual Residence of Decedent 10a. State 10b. County MD	10c. C	City, Town or Location	Baltimore			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f shu notified at once, al Director	10e. Street and Number 2704 Overland Aver	nue	10f.	Zip Code 21214	10g.	Citizen of What Cou.	ntry? SA
2 hours after death wi "natural", or items a Examiner must be eted by Funer?	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo 15. Decedent's Education (Spec	If Yes 2 Norced If Yes, Give Year or Dates:	If Yes, spondo 1 Yes	edent of Hispanic Origin? (secify Cuban, Mexican, Puert 2 No specify: ual Occupation (Give kind of working life. DO NOT use re	to Rican, etc.) f work done	White, etc. Specify: Sb. Kind of Business/	white Industry
MD 21215-0036 d 2 should be filed within 72 hour tht and Montal Hygiene. n 27 is marked other than "naturumatic event, the Medical Exam To Be Completed	8 17. Father's Name (First, Middle,	Last) Charles Johnson			ne (First, Middle, Mai Virg		771
VD 212 2 should be the and Menta 27 is mark umatic even To B	19a. Informant's Name/Relationsh Brenda Johnson / Sis	ter	2704 Overl	ess (Street and Number or and Avenue, Balti	more, MD 212	214	
Baltimore, I permit. Pages I and Department of Healt Important: If item	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp. 21. Signature of Funeral Service	3 Removal from State ecify:		ce)	/20/2012		ille, MD
Physician Medical Examiner	Dorota Marshall 23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. Hypertensive	eath. Do not enter the mode. Atheroscle	de of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
r Kaminer	or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) C. Due to (or as a consequence) d.	ce of):				
Division of Vital Records, P.O. Box 68760, To the Hospital nr Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit ledical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	pregnancy 2 Fetal de			23d. Date of deliver Month	y Day Year
cords, P.O. Box 6876 is a requires that the death certificat has been signed by the attending phore is should be detached for use as the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the prope	Dichetes Mol	ons contributing to death but n	not resulting in the underly	ring cause given in Part I.	1 Yes	2 No 3 Pro	the cause of death? bably 4 Unknown utopsy findings available
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Division o To the Hospital nr Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune fedical Certification:		d not be mined 28e. Place of Injury - (Specify) systician: To the best of my known	At home, farm, street, fac		or Town, Stat	e)	ural Route Number, City
To the Hospital within 24 hours To the Funeral completely fille	(Check only one) 2 Medical Example 29b. Signature and title of certifie	niner: On the basis of examination and manner stated.	ion and/or investigation, in	n my opinion, death occurred	d at the time, date an	d place, and due to the	ne cause(s)
X A	30 Name and address of person		(Kem 23a)	O.C.M.E.		September 17, 2	2012
State Registra		. Assistant Medical Ex		saitimore Street, Balt	imore, MiD 2122		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 8 10 A M 2. Date of Death Kim Lee Kent, Sr. Physician/ SEPTEMBER 12, 2012 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JUSEPH MEDICAL CENTER TOW SON BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Hours 220-64-8062 56 Director 1 M 2 F 5/6/1956 MD 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Eveniner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1928 Sherwod Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) most of working Clerk Enumeration Elementary/Secondary (0-12) College (1-4 or 5+) 12th Finance and Social Securt. Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Kent Page 1 and 2 should be Katherine Lockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kim Lee Kent, Jr.-Son 3432 Ravenwood Ave.Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Pk. 9/19/2012 4 Donation 5 Other (Specify) King Randallstown, tun Funeral Service, Licensee 22. Name and Address of Facility March F/H- East 1101 E. North Ave. BAltimore, 21202 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy sate has been signed by the atterpage 2 should be detached for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Enpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of : After ! Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 24 hours after death. Funeral Director: A 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OSLER DRIVE TOWSON, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Louise King 20^{rgar}2 Medical 4:00 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 90 234-26-7122 Director 1 M 2 F 7/18/1922 WV Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location must be notified at Director 10d. Inside City Limits WV Tucker Parsons 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 26287 908 Licking Creek Road USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. the Medical Examiner Black, White, etc. "natural", or ģ ☐ Never Married 2 ☐ Married within 72 hours after Yes Yes, Give Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 1 ☐ Yes 2X No Specify: Completed Specify.whit e Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)
Mary Louise Jamison and Mental I permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Forrest Wesley Swisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
522 Dorsey Ave Essex MD 21221 Judith A. Horst daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Morent Pace)
Morent Pace (Pace)
Memorial Date 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 9/17/2012 Elkins WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harman Funeral Service P 7221 Grayburn Dr Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate carrier. Enter Theorem, Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No the shed 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been si Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 s certificate has director, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier

State Registrar

The Harity

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kettarathi

31. Date filed (Month, Day, Year) SEP 2 0 2012

29d. Date signed (Month, Day, Year)

9000 Franklin Square Dive Raltimore MD 21237

SEP, 13,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Decedent's Name (Fig. 1)	irst, Middle,La	st)	-	2			2. Date of I	Death	3. Time of Death
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		4a. Facility Name (if not				4	b. City, Town, or I	Location of D	eath	4c. County of [Death
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Funeral		5. Social Security Number	oer 6. S	ex	7. Age (In yrs.	last birthday)	If Under 1 Year			Birth (MM/DD/YYYY)	J. Birthplace (State or oreign
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Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate Its after death. **I Director: After this certificate has been signed by the attending physical ind in by the funeral director, page 2 should be detached for use as the bill.	ā								1 🗆	Yes 2 No 3	Probably 4 V Unknown
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		4 Homicide 29a. Certifier 1 Cert		(0,000))	Woods						
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d l		30. Name and ddress of					- W -				
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12-06922 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene lan Loughran 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** Ian Adam Loughran 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Pvlesville 400 St. Mary's Road If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Director 43 1 X M 106-66-0376 2___F Yrs May 27, Usual Residence of Decedent 10c, City, Town or Location an y 10a. State 10b. County permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury nr other traumatic event, the Medical Examiner must be notified at once. Maryland Pylesville Harford Director 10e. Street and Number 10f. Zip Code 21132 400 St. Mary's Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married 2 X No Yes If Yes, Give Yee: 1 Yes 2 No specify: 3 Widowed 4 Divorced ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Deputy Sheriff 17. Father's Name (First, Middle, Last) Be Walter Thomas Loughran Jr. 19a. Informant's Name/Relationship (Type, Print) Tonya Loughran / Wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place 1 Burial 2 Cremation 3 Removal from State 9-19-12 Highview Mem. Gdns. 4 Donation 5 Other Specify. ignature of Funeral Service Licen Bai **Physician** failure, List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit d. Ca UNPENDED AMENDED Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pleted After this certificate has been s funeral director, page 2 should 24a. Was an autopsy performed? Com 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 DOA Inpatient 2 ER/Outpatient 3 ၉ 1 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending 1 Yes 2 No the 2 Accident Investigation

0526 hrs September 13, 2012 4c. County of Death Harford 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or oreign Country) New York 1969 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, Specify: White 16b. Kind of Business/Industry County Government 18.Mother's Name (First, Middle, Maiden Surname) Donna Marie MacLeod 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 St. Mary's Road, Pylesville, MD 21132 20c. Location - City or Town, State Fallston, Maryland ²². Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available death? ✓ Yes 2 No 1 Yes 2 No Hospital or Atteoding Physician: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 13, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State 31. Date filed (Month, Day, Year, Registrar

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30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31 Date filed (Month Company) 6 32. Registrants, Signature	To To Com	Me		29c. License nu	umber		29d. Date signed (Mo.	nth, Day, Year)
Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			Carde Hellan	O.C.M.E	E.		September 17, 2	012
State 31 Date filed (Months Com Year) a 32 Registrar's Signature					D. III	4D 04000		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :50PM ANNE VIRGINIA WILLIAMS MCKENNEY Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMOR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days (Month, Day, Year) 214-20-9680 Director 1 □ M 2 💢 F 87 May 16, 1925 Maryland ortant: If item 27 is merked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 ☐ Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 72 Murdock Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 N Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Residence Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be filk Department of Health and Mental i Important: If item 27 is merked o John Richard Williams Emma Loretta Tiepie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8615 Drumwood Road, Towson, Maryland 21286 Charles R. Williams timore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/22/2012 Baltimore, Maryland Signature of Funeral Service Peners aus Bai MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ed by the detached g 🗌 Unknown within 24 hours after death.

To the Funerei Director: After this certificate has been signed by i completely filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) ٥ 0065 Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, State Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death sept. Physician/ 2012 14. 10:30 A M Betty Balton Martin Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring JK House of Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year, Country) Director 069-14-6582 89 1 M 2 X F Dec. 10,1922 Romania Usual Residence of Decede items 23a or 28a-f show ner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b. Count with the Maryland Director 1 ☐ Yes 2X No Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20906 USA Funeral 12812 Saddlebrook Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S ural", or item Il Examiner ก 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2X No Specify If Yes Give White "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry during most of working (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be filed timent of Health and Mental Hitant: If item 27 is marked other ည Leah (unk) Isador Baltowsky other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12812 Saddlebrook Dr. Silver Spring, MD 20906 Kathleen Martin / daughter Baltimore, Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State Final Journey Crematory 9/19/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of uneral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Conjestive Heart Failure resulting in death) Medical Examiner Ischemic Heart Disease Sequentially list condition Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes Mellitus II use as the burial-tran that initiated events ding physician and Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Year Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? been signed the should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, The law requires Dementia Completed prior to completion of cause of death? 24a. Was an 24b. Were autopsy findings available Hyperlipidemia autopsy performed' 1 🗌 Yes 2 😾 No Hypertension 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Assisted 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မြ 28a. Date of injury (Month, Day, Year) Living funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After t work? injury 1 X Natural 5 Pending 2 🗌 No Accident Investigation To the Funeral Director: , completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature apd itle of certifier 29c. License number Sept. 17, 2012 D37830

State Registrar 3416 Olandwood Ct. Suite 207 Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

32. Registre 's Signature

Johny Edappully,

12-06938 Mark Madore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 30084

		1- For State Registrar	Certific	cate of	Death		F	Reg. No		
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Dea	Day	Year	3. Time of Death
Medical Exami	ner	Mark Madore		141	City Town	r Location of Do	Septemb		c. County of Dear	1625 hrs
		Facility Name (if not institution, give street and number) 4301 Wabash Avenue		41	Baltimore	or Location of Dea	atri	*	c. County of Deal	ın
Funeral			(In yrs. last b	irthday)	If Under 1 Ye	ar If Under 24h	irs. 8. Date of B	irth (MM	/DD/YYYY) 9. B	irthplace (State or
Director		216-78-2760 1KM 2F	54		Months Da		Nov 16		Fore	
		Usual Residence of Decedent		115.	LL		1100	,	557	145
en.y			Oc. City, Tow	n or Locatio	n					10d. Inside City Limits
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2 2 1	뒨	1 Yes 2	X No							
s afte	Ď	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comp	leted) 16:		Yes 2X N	o s <i>pecify:</i> ation (Give kind o	of work done	116h	Specify: Wh: Kind of Business	
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21215-0036 21215-0036 Julid be filed within 7 Mental Hygiene. marked other that	Be	Arthur Joseph Madore					eth Cece			
D 21 hould hould Me	မ	19a. Informant's Name/Relationship (Type, Print)					or Rural Route Nu			e, Zip Code)
bre, MD 21215-003 s. I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the fraumatic event, the Med		Danielle Madore/daughter 20a. Method of Disposition			ance Dr		nington,		28405 Location - City o	r Town State
Ore, of He of He brit		1 Burial 2 Cremation 3 Removal from State	crem	atory or other	er place)				•	
limor Pages ment of tant: If		4 Donation 5 Other Specify:	Final		_	г	09/20/12		odbine,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examines		21 signature of Funeral Service Licensee		FO11	ame and Addre	ss of Facility Cremati	ion Servi	ice	P.O. B	ox 784
Physician	-	23a. Part i. Enter the disease, or complications that caused the	MO125	1 Beve	eriv L.	Heckrot	te. P.A.	. C1	arksvil	le, MD 21029 Approximate Interval
//Medical		failure. List only one cause on each line.								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple I Due to (or as a consection)	njurie quence of):	s	<u></u>					
		Sequentially list conditions, b								
	je.	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	quence of):							
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of Vital Records, P.O. Box 68760, g. Physician: The law requires that the death certificate be executed for this certificate has been signed by the attending physician and neral director, page 2 she uld be detached for use as the burial - trans	Ω.	Part II. Other significant conditions contributing to death	but not result	ing in the ur	derlying cause	given in Part I.				the cause of death?
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		27. Manner of Death 1 Natural 5 Deading (Month, Day,Yei	y 28b ar)	o. Time of In	· _	ury at Work?	28d. Describe		•	*****
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Division pital or Attendion ours after death. eral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify)	iry - At home, 'rain T		, factory, office	building, etc.	or Town,	State)	4301 Wab	ural Route Number, City ash Ave.
ospits hours unera		4 Homicide	knowledge s	dooth occurr	ad at the time	data and place s	Baltim			stad
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	(Check only one) 2 Medical Examiner: On the basis of exam								
witi To	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d.	Date signed (M	onth, Day, Year)
i	100	Por a - too.			0.0	M.E.		Se	ptember 14,	2012
		30. Name and address of person who completed cause of de	ath (Item 23a	1)						
Y		Patricia Aronica-Pollak MD. Assistant Me	edical Exa	miner 9	900 W. Balt	imore Street	, Baltimore, M	1D 21:	223	
S Regis		31. Date filed (Month, Day Year) 32. Registrar	s Signature	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month September 201 10:53 AM Theresa Morgan Rosemary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. Director 219-56-5764 1 □ M 2 🛛 F Aug 30, 1963 49 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Ouail Wood Court 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 n/a Assembly Line Personnel Manufacturing permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ DiVenti Salvatore Tuminello Rosemary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16302 Matthews Road, Monkton, Rosemary DiVenti /Mother MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/19/2012 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State 4 Denation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. F ter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r he rt failure. List only one cause on each line. Approximate Interval Between Immediate a _e (Final disease or condition resulting in death) Onset and Death Physician/ Metastatic and) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many Examine Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 🗓 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မြ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital (24 hours a Medical 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 D71040 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) ARATHI CHARLES KUMAR 31. Date filed (Month, Day, Year) SEP 2 0 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Joseph McEntee, Sr. Physician/ September 18, 2012 10:30A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death Baltimore 1323 Roland Heights Avenue Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year Feb 9, 1934 **Funeral** 9. Birthplace (State or Foreign Months Days Min. 1XXM 2 □ F Country) 213-30-1409 78 **Director** Usual Residence of Decedent show 10a. State 10b. County the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director N/A **Baltimore** MD 28a-f 1XXYes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral with U.S.A. 1323 Roland Heights Avenue 21211 72 hours after death Was Deceus... Armed Forces?... Ves 2 XX No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 XXMarried ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: White 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than ' within 7 mentary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha City of Baltimore Water Meter Reading & Billing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Catherine E. Donnelly 1 and 2 should be fi f Health and Mental ပ John J. McEntee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Frances McEntee (Wife) 1323 Roland Heights Avenue Balto, MD 21211 20b. Place of Disposition (Name of prematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 Burial 2 XXCremation 3 Removal from State Atlantic Crematory or other 9/19/12 4 Donation 5 Other (Specify) Glen Burnie, MD any in Signature of Funeral Service Lic 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition nmib Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the. as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Dav Year Pregnant at time of death be detached Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 🗌 Yes 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospita Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 5 Residence 6 Other (Specify) funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No injury the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death within 2 occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and of ce 29d. Date signed (Month, Day, Year) ð and address of 31. Date filed (Month, Da State 2 Registrar

DHMH 17 Rev 7/2009

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	For	State of Marylan				,	gione			
_	State Registrar		Certi	ficate of D	eath		Reg. No.	2012	3008	
nysician/	1. Decedent's Name (First, Middle, La.	,				2. Date of De		Year	3. Time of Death	
Medical		-EWSKI				Septemb	er 18,	2012 Year	2:45 A M	_
xaminer	4a. Facility Name (if not institution, give	e street and number)	4		Location of Death			County of Death	1	
neral	1106A Beach Promenade 5. Social Security Number 6. S	ex 7. Age (In yrs. I	ast hirthday)	Orchard f Under 1 Year	I Beach If Under 24 Hrs.	8. Date of Bi		ne Arunde	lace (State or Foreign	_
ctor		Х м 2 П Е		lonths Days	Hours Min.	(Month, D		Count		
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To Be Completed by Funeral Director	10a. State 10b. County	10c. Cit	y, Town or Locat	on				1	0d. Inside City Limits	
įį	Maryland Anne Aru	ndel Orch	ard Beach						1 🗆 Yes 2 🔀 No	_
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ed	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	1 🗆	Yes 2 X No	Specify:		Sp	pec <i>ify:</i> Whi	te	
Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deceden	t's Usual Occupa	ition uring most of work	ina	16b. Kind	of Business/Inc	lustry	-
E O	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO N	(OT use retired)	-	my				
Be C	17. Father's Name (First, Middle, Last)	N/A	Chemi	cal Loader					nt Company	_
To E		1			18. Mother's Name	e (First, Middle Hud		rname)		
	William Miles 19a. Informant's Name/Relationship (7)		10h Mailine		Ilena			- 01 - 7: 0		
	Joshua R. Milewski (S				nd Number or Rura nue Glen B				ode)	
	20a. Method of Disposition	20b. P	lace of Dispositi	on (Name of		Date		ation - City or Tox	wn, State	-
	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		emetery, cremate Haven Me	ory or other place n Pk	09/21/	2012	Glen P	Burnie, Ma	rvland	
	21. Signature of Funeral Service Licens	Jouci	22. N	ame and Address	s of Facility				т утели	-
	John of	fl_	MgC 320	ully-Polyn 4 Mountain	niak Funera 1 Road Pasa	I Home. dena. Ma	ryland	21122		
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the deatl	n. Do not enter th	ne mode of dying,	, such as cardiac o	or respiratory a	rest,		Approximate Interval Between	i
1/	Immediate Cause (Final disease or condition	LUNG C	ANCE	0 =	METC.				Onset and Death	
	resulting in death)	Due to (or as a consequ							10010	-
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Exal	that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):							_
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sicis	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of d		ther (specify)				Month	Day Year	
Physician/M	9 Unknown		This are the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state		. In Post 1	1				_
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י חו						24a. Was auto	psy	prior to con	sy findings available npletion of cause of	
mple							rmed?	death?		
Completed	OF West						2 No	1 🗆 Yes 2	2 No	
Be	25. Was case referred to medical examiner?	Hospital:		Othor	ce of Death (Check	1 \(\superset \text{Yes}\)	2 No		2 No	_
To Be	evaminer?	1 Inpatient 2 28a. Date of injury	ER/Outpatient 3	B DOA Other	4 Nursing Ho	1 ☐ Yes conly one) me 5 ☐ Resid	2 No	Other (Specify)	2) No	-
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To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	1	28b. Time of injury	DOA Other. 28c. Injury a work? 1 \(\text{Y} \)	4 Nursing Ho at ;	t only one) me 5 Resi 28d. Describe I 28f. Location (2 No dence 6 now injury or	Other (Specify)		_
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Medical Certificate: To Be	examiner? 1	28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specify, sician: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practically and the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a property of the basis of examination are practically as a pro	28b. Time of injury me, farm, street, edge, death occurand/or investigative knowledge, death 23a) (Type, Print	DDA Other. 28c. Injury a work? M 1 Y Y factory, office urred at the time, ion, in my opinion atth occurred at the 29c. License r D 0 05	4 Nursing Ho at es 2 No date and place, ar , death occurred at e time, date and pla number	1 Yes conly one) me 5 Resi 28d. Describe I 28f. Location (City or Toy and due to the c	dence 6 now injury or street and Nown, State) ause(s) and place, are the cause(s): 29d. Date s	Other (Specify) courred lumber or Rural R manner as state d due to the caus and manner as st signed (Month, D EMBER	Route Number, d. se(s) and manner stated ated. ay, Year)	_
Medical Certificate: To Be	examiner? 1	1 Inpatient 2 28a. Date of injury (Month, Day, Year) 28a. Place of Injury - At ho building, etc. (Specify, sician: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are Practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: On the basis of examination are practitioner: To the best of my knowliner: To the best of my	28b. Time of injury me, farm, street, edge, death occurrence and/or investigative knowledge, death 23a) (Type, Print	DDA Other. 28c. Injury a work? M 1 Y Y factory, office urred at the time, ion, in my opinion atth occurred at the 29c. License r D 0 05	4 Nursing Ho at es 2 No date and place, ar , death occurred at e time, date and pla number	1 Yes s only one) me 5 Resi 28d. Describe I 28f. Location (City or Tow and due to the c the time, date a toe, and due to	dence 6 and Now, Street and Now, State) ause(s) and and place, and he cause(s): 29d. Date s	Other (Specify) courred lumber or Rural R manner as state d due to the caus and manner as st signed (Month, D EMBER	Route Number, d. se(s) and manner stated ated. ay, Year)	_

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September September Physician/ Shoemaker Moyer 2012 7:35 P M Theodore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Edgewood 219 Kennard Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) Director 220-26-0481 1X M 2 🗆 F 83 1929 Usual Residence of Dece Maryland an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 219 Kennard Avenue USA 21040 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement Major Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F pe Theodore Shoemaker Moyer Helen (nmn) Kahler traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Elaine Tucker Moyer / Wife 219 Kennard Ave., Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any Injury or o Page 1 1 □ Burial 2 🛭 Cremation 3 □ Ren State 4 Donation 5 Other (Specify) Rose Hill Svcs, LLC 9-20-12 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. re of Funeral 21. Sig 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ONG FAILIULE MEALL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to transcillate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Whatural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 💭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 92 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21015 151 212 BEL F. MAHMOOD EMMORTON 00 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September Da Day Physician/ 11:45рм Elizabeth Nigro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 407 Russell Avenue, Apt. #512 if Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Georgia **Funeral** (Month, Day, 01/28/ Months 1 □ M 2 🛛 F 88 Director 252-40-2552 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral or items 23a 20877 407 Russell Avenue, Apt. #512 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: "natural", Caucasian Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Latimer Raymond Harrison O'Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 90 Casper Court, Port Chester, New York 10573 Susan Elizabeth Nigro/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 09/21/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signatur of Funeral Service Lio ns 1100709 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Opset d Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Securately list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day for Month Pregnant at time of death 5 Other (specify) the a 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 Probably 4 Unknown 2 3 No 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available page 2 s autopsy you te performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Registrar

Medical

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. ROBERT BIRSCHBACH,

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

GALTHERSOUNG, MIS 208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 14 2012 SIDNEY NEWBERGER 11:55P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. Months Days Director 213-30-2523 1 X M 2 □ F 79 Usual Residence of Decede 07/06/1933 MD 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 Yes 2 X No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? any injury or other traumatic event, the Medical Examiner must be Funeral with 3310 MIDFIELD ROAD 21208 USA items. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 DENTAL TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NATHAN NEWBERGER **EDNA** EZERSKY 19a. Informant's Name/Relationship (Type, Print)
Phyllis Newberger/Wife
PHYLLIA NEWBERGER/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 3310 MIDFIELD ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 09/19/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Ser 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ 5146E END disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause in the Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural Accident 5 Pending injury work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital 24 hours Medical 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I

State Registrar 29b. Signature and tit

Baltimore, Maryland 21215-0036

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nend #20b Per FH G932 10/09/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 12 mill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba where lare anton Markor Balhmore 1 hmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1□ M 2**X**F Months Days Hours Min. 217-20-1534 Director 2,1921 MAUCH Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 □ No **Funeral Directo** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1511 E. Biddle STREET u.s.A "natural", or items 23a 21213 permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: AFRICAN 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 <u>ج</u> 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced AMBRICAT Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BAUTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel MARY Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FECK NEPHEN DRIVE. BALTO, MD. 21234 HEDERICK 6832 STURBLIDGE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date JAJIK 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 10/16/2012 Arbutus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) BALTIMOR my y Land 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCUS 21. Signature of Funeral Service Licenses 4905 YORK ROAD, BANTIMORE, MD. 21212 MO1636 only one cause on each line. art 1. Enter the di ase shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) APheroslerotic Physician /Medical Due to (or as a consequence of): 10 years Examiner Baseks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Ye ar 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 X No 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 10061677 nal dan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONAL thware OSON KAREN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 17, 2012 1:30 AM September LEONARD PARR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore City GENESIS ELDERCARE: Long Green If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 90 May 17, Director 220-07-3086 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 115E Melrose Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23s any Injury or other traumatte event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? '43-'46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Industrial Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Feodor Paranuk Helen ပ Luzenko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 Americana Drive, Apt.55, Annapolis, MD 21403 (Daughter) Maria K. Parr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/25/2012 Catonsville, Maryland 21. Signatur of Funer Service Census Martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Securedally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pnsequence of): Examiner burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Nonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician certificate After this Hospital or Attending death. 24 hours after death e Funeral Director;

with the Maryland

Maryland 21215-0036

Baltimore,

nse for detached pe funeral director. the filled in by

completely To the P within 2

29a. Certifier (Check only one) 29b. Signatu

3☐ Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Magical DIRecto

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30 per DVR, g931 9-20-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day SEPTEMBER 7:34 P M MARGERY K POZEFSKY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2418 STILL FOREST ROAD BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Country) **Director** 220-42-9022 1 🗆 M 2 🗶 F 71 04/09/1941 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2418 STILL FOREST ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify. Year or Dates WHITE or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) ARTIST AND JEWELER ART Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be filed of Health and Mental H ၉ T. DANIEL KOLKER RUTH SAMLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 STILL FOREST ROAD, BALTIMORE, MD THOMAS POZEFSKY/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 09/19/2012 REISTERSTOWN, MD . Signature of Funeral Service sid 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vng disease or condition Moule Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mo Month Day Pregnant at time of death Year the the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Amal Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown plnods Vansalom Lwith i murro survession 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

eral Director; Aft
filled in by the fur Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie unus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Pozefsky 10755 Falls Rd. Ste: 200 Lutherville, MD, 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 17^{Yea}20 FRANCIS POUX 2 2 рм Α. Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. JOHN NEUMANN RESIDENCE TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours **Director** 199-24-1783 1 XM 2 □ F 11/01/1933 78 PENNSYLVANIA Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 X No MD BALTIMORE TIMONIUM ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2300 DULANEY VALLEY ROAD 21093 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ö þ 1 X Never Married 2 Married Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5 + PRIEST CATHOLIC CHURCH other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ TAILLIEZ GEORGE Α. POUX, M.D. GERMAINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or are REV. G.SZYMKOWIAK/CONFRERE 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State SACRED HEART OF JESUS 9/21/1 2 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral S ervice Licensee ZZ Name and Address of Facility R INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ oronaru 00 Jeavs disease or condition Medical resulting in death) Due to (or as a consequen Examiner 2012 Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and I-trar Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical certificate be Box 68760 SEPTEMBER the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day signed by the at Id be detached for Pregnant at time of death 1 Yes 2 No Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1 ☐ Yes 2 → No Yes FRANCIS POUX 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1-Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie 8m License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) istrar's Signature State

DHMH 17 Rev 06-2011

Registrar

			Please For State Registrar	e Type or Pri amend 2 State of M amend 2	nt in Blac 3a, pt. I avyland / I 3b-c, pe	k Inde	lible In PHY go legit of the sate of the	k. Ensure 31 9–20 eath and Death	All Copie Mental Hy	s Are L	egible.	30005
	Physicia Medic		Decedent's Name (First, Middle, Laguere)	ast))uach	Ocrano	ato or E		2. Date of De Month 09		Year 2012	3. Time of Death 4:00 P M
man.	Examir Funeral Director		212-43-9490	l Rehab	e (In yrs. last birt		nder 1 Year	Silver Sprin If Under 24 Hrs Hours Min	8. Date of Bi	rth	Cour	omery place (State or Foreign
-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at	leted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Mon 10e. Street and Number 2101 Fairland Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's	12. Was Decedent E Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.	No	13. Was Do	ecedent of H specify Cube es 2 X No		pecify Yes or No	Sp	can Indian, etc. sian	
Maryland 21215-0036	should be filed within 72 hand Mental Hygiene. 7 Is marked other than "n reumetic event, the Med	To Be Completed	(Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (19b	(Give kind of life. DO NOT	Give kind of work done during most of working fe. DO NOT use retired) Welder 18. Mother's Name (First, Middle, Maiden Surnar, Ngai Lam Mailing Address (Street and Number or Rural Route Number, City or Town,						
Baltimore, N	permit, Pege 1 and 2: Department of Health Important: If item 27 eny Injury or other tr once.		Terry Quach / Son 20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Spec 21. Signature of Funeral Service Licer Dorota Marshall	ify)	20b. Place of cemeter	f Disposition ry, crematory apeake (22. Nam	(Name of or other place Cremator e and Addre	y 9/	Date 15/2012	20c. Loca	Beltsville	
	23a. Part 1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last 23a. Part 1. Enter the disease, or complications that caused the death. It is not cause on each line. Due to (or as a consequence of the property of the initiated events resulting in death) Last Due to (or as a consequence of the property of the initiated events resulting in death) Last Due to (or as a consequence of the property of the initiated events resulting in death) Last					rest St				rest,	1	Approximate Interval Between Onset and Death Yr
ds, P.O. Box 68760	Attending Physician: The law requires that the death certificate be at death. sctor: After this certificate has been signed by the attending physici by the funeral director, pege 2 should be deteched for use as the by the funeral director.	ted by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Part II. Other significant conditions Hypertension	•	2 Fetal death	5 \(\sum \) Othe	er (specify) _	N/A		23d. Date of delivery Month Day Year I tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown		
of Vital Records,	i clan : The law rec certificate has ber rector, pege 2 shc	Completed by	25. Was case referred to medical	1		-	06.00	and of David Office	1 🗆 Yes		24b. Were auto prior to co death? 1 \(\sum \text{Yes}	ppsy findings available ompletion of cause of
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ia •	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	(Check 2 <u>⊔</u> Medical Exar	n iner: On the basis of e	my knowledge, xamination and/o	r investigation	urred at the time, date and place, and due to the cau ion, in my opinion, death occurred at the time, date and th occurred at the time, date and place, and due to the 29c. License number			cause(s) and and place, and the cause(s) a	nd due to the ca	use(s) and manner stated. stated. Day, Year)
	Sta Registr		30. Name and address of person who Tania Alchalabi, M.D., 1 31. Date filed (Month, Day, Year) SEP 2 0 2012	5245 Shady Gro		#130, Ro	ckville, l	D 0074668 MD 20850			07.13.20	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PI LINE B State of Maryland 9 Department of Health and Mental Hygiene AMEND Reg. No. 20 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 19,2612 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. Funeral Hours Min Months 10-7-1940 Director 214-38-5765 1 M 2 DXF PENNSYLVANIA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State death with the Maryland Director MD N/A EAST END tX☐ Yes 2 ☐ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 5042 EAST FEDERAL STREET 21205 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Was Deceuen ____ Armed Forces? 1 ☐ Yes 2 💢 No Black, White, etc. 2 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ament of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates WHITE 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ FRANK SAXTON THELMA SHANNON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5042 EAST FEDERAL ST BALTO., MD 19a. Informant's Name/Relationship (Type, Print) PHARES REICHARD/HUSBAND 21205 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other? 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) METRO CREMATORY 8-21-2012 4 Donation 5 Other (Specify) CATONSVILLE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE 21237 ROSEDALE, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner AGONAL ASPIKATION PNEUMONIA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con CERTIFICATION APPROVED BY MEDICAL EXAMINATION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's 1 🗆 Yes 2 🗆 No Yes 2 N 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မူ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hai tham 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 20 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death September 19ay 2012 Year Physician/ 1:20P ROMME MARY ANNE EAGERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 218-26-8447 1 □ M 2**XX**F Director 02/02/1928 Maryland 84 r man "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State with the Maryland Director 1 Yes XX No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 702 Murdock Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Hame Homemaker Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ၉ Mary Spurrier Joseph Alban Eagers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Gothard Road Timonium, Maryland 21093 19a. Informant's Name/Relationship (Type, Print) Son John Paul Rommel f Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XX Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, 109/20/2012 Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) inature of Funeral wice Livensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) non-small cell Physician/ LVNG Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician end stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? ☐ Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner r Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Spice 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 2012 Seprember 20 D58303

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State Registrar

31. Date filed (Month, Day, Year)

6701 N. Charles ST Towson AARON J CHARLES MO 32. Recentrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, 2012 Physician/ Sept. Suryanarayanan Ramayyar 4:12 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 220-83-6256 1 🕅 M 2 □ F May 12,1934 India Usual Residence of Dece item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD North Potomac 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 USA 11124 Lake Breeze Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Indian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ild be filed within Mental Hygiene. Engineer steel Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Gnanambal** (unk) Mannarqvdi Sivarama Ramayyar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 shament of Health a tant: If item 27 is 11124 Lake Breeze Drive, N.Potomac, MD 20878 Sury Chudamani / son Itimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/18/12 Woodbine, MD 21. Signatur colonegal Service Licensee Bal Going Homes Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. esophagen carcinoma Onset and Death Immediate Cause (Final netas Physician/ tatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? Yes 2 N N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{ Nursing Home } 5 \) Residence 6 \(\text{ Other (Specify)} \) 1 🗌 Yes 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olney, Maryland 20832 Chitra Rajogopalimo Prince Philip Dr. # 327, 18111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

September 12,201

SURYANARAYANAN

RAMAYYAR,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER MICHAEL RICHMAN 2012 11:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Country) **Director** 212-36**-**4124 1 X M 2 □ F 71 02/09/1941 MD Usual Residence of Decedent 28a-f shor 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified a BALTIMORE PIKESVILLE 1 Tes 2 No 10e. Street and Number ò 10g. Citizen of What Country? ıral", or items 23a o Funeral 3113 OLD POST DRIVE 21208 USA and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed WHITE traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER ENTERTAINMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RICHMAN BESSIE HERLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JORDAN RICHMAN/SON 3113 OLD POST DRIVE, PIKESVILLE, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BNAI ISRAEL CEMETERY 09/19/2012 BALTIMORE, MD re f Fune I Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Part 1. Enter the disease, or complication shock, or heart failure. List only one of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ LUNG Cance Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death the Division of Vital Records, P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura and title of certifier

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State Registrar

Registrar SEP 2 0 2012

Jason /Sla

mD

Lec

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0061199

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mitchell september Radinsky 9:157 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Hours (Month, Day, Year) Director 577-26-6247 1 □XM 2 □ F 89 03/31/1923 PA Usual Residence of Decede 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 1 Yes 2 □ No N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7121 PARK HEIGHTS AVENUE, UNIT 310 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Specify: WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MECHANIC AUTOMOTIVE B B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever marked o မူ BENJAMIN RADINSKY GUSSIE GOTTESFELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEATRYCE RADINSKY/WIFE 7121 PARK HEIGHTS AVE, UNIT 310, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
LAZAR RISSA SKLAR
FAMILY CIR (FORBAND) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/19/2012 BALTIMORE, MD Signature of uneral Service bi 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dusphingia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit the attending physicien and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Veal Pregnant at time of death 2 No 1 Yes 2 9 Unknown g 🗌 Unknown o me runeral Director: After this certificate has been signed by 1 completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specify 1 has pice မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation М 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MSKLYAPAREMO 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5703 NSKujapakseMD 2835

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/26/12 Physician/ Eunice Mae Swanson 3:13pmu Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2104 Piney Branch Circle, Apt432 Hanover Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

AL **Funeral** 8. Date of Birth (Month, Day, Year) 11/26/31 280-30-6478 1 M XX Months Days Hours Min **Director** 80 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Hanover 1 Yes 2 XX 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2104 Piney Branch Circle, Apt 432 21076 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc ģ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked otherway injury or other the one. 12 Medical Registered Nurse Be 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) Williams Frank ည Willa Pace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belynda Swanson-Newell/Daughter 2104 Piney Branch Circle, Apt432, Hanover MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Cleveland Mem Gardens 1 Burial 2 Cremation 3 Removal from State 9/1/12 4 Donation 5 Other (Specify) Cleveland, 21 Signature of Funeral Service Licensee Victor P. Doda 22 Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
Reltimore MD 21230 1501 E. Fort Ave, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition AILURE MONTHS Medical resulting in death) Examiner CMCNT y cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Die to (or as a consequence of): Exami nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the atter Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed certificate 2 No 1 ☐ Yes 2 🗷 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 KNo Hospital Other: 1 Yes 2 After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? or Attending F after death. 28d. Describe how injury occurred (Month, Day, Year) 1 ANatural 5 Pending n 24 hours after death.

Le Funeral Director: A pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner: To the best of my knowledge, death conume at the time, data and place, and due to the causele) and manner as stated 29b. Signature and title of certif 2 29d. Date signed (Month. Day, Year) 40047494 8/21/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANGSTON. P.O. 1614 FOREST ONIQUE

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12-06481 Philip Paul Sellm	nan	Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and			ible.	
		1- For State Certificate of Death	·	_	1. No. 201	2 3010
Physicia		1. Decedent's Name (First, Middle,Last)		Date of Death Month		3. Time of Death 0940 hrs
Medical Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L.	ocation of Death	Month August 28,	2012 4c. County of Death	
		124 Broadway Apartment 2 Hagerstown			Washington	•
Funera!		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs.	. 8. Date of Birth		thplace (State or
Director		115-76-0436 1MM 20F SCYrs. Months Days	Hours Min.	4-10	57 Foreig	untry) MD.
		Usual Residence of Decedent			<u> </u>	
Ma W		10a. State 10b. County 10c. City, Town or Location	_ \			10d. Inside City Limits 1 Yes 2 No
yland P-f shc	ţċ	10e. Street and Number P10f. Zip Code Up	OWN	110	. Citizen of What Cou	
or 28;	Funeral Director	10.1 ROCAS ATT	NK.	100	g. Citizen of what Coul	<u> </u>
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leath v	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, I	Mexican, Puerto	Rican, etc.)	White, etc.	•
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	specify:		Specify: W	NIE
hours natur Exam	ed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. D			16b. Kind of Business/	ndustry
36 uin 72 than dical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	= 0 1 10	,	Note West). .
d with	Completed	17. Father's Name (First, Middle, Last)	8.Mother's Name	(First, Middle, Ma	aiden Surname)	ENTRACTOR
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show any natic event, the Medikal Examiner must be notified at once.	Be	JAMES SELLMAN	DA	SLA A	relas	
21 hould ad Mes is man	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	and Nu ber or R	Rural Route N	er, City or Town, State	, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f she re other traumatic event, the Medical Examiner must be notified at once		CORD FORMS, SISTER BOI WhITE WATE 20a. Method of Disposition (Name of ceme	SRUAYT	3016EA	BURNIE, 1 20c. Location - City or	10 2 ille
Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If them 2 njury or other traun		1 Burial 2 Cremation 3 Removal from State crematory or other place)	etery,	Date	20c. Location - City or	rown, state
· E Z ? I		4 Donation 5 Other Specify: WARRY GUATED		31-12	O'DENTON.	, MD.
Balti permit. Departn Import		21. Signature (Funeral Service Licensee) 22. Name and Address of	of Machity DAL	IGHERT		gal Homé
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin Intoxication				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	xamine	cause. Enter Underlying Cause				
nsit ed D		events resulting in death) Last Due to (or as a consequence of):				
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Box 68760, e death certificate be the attending physical for use as the bur	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregna	ncy		ay Year
OX (leath ce aftended for use	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown				
P.O. B that the demed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by			1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d				
To Wi	Æ	and manner stated. 29b. Signature and title of certifier 29c. License r	number		29d. Date signed (Mor	oth, Day, Year)
		hich oc.M.	I.E.		August 29, 2012	
\wedge	ı	30. Name and address of person who completed cause of death (Item 23a)				
4		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltim 31. Date filed (Month, Day, Year) 32. Registrar's Signature	more, MD 212	223		
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 0 2012 SEP 2 1 2012 SEP 2 1 2012	<u></u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SaNDERS Physician/ Month 09 5 ALFREIDA 2012 Medical 4a Facility Name (if not institution, trive street and number) Examiner 4c. County of Death If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State Country) **Funeral** Hours Director 1 M 2 ME 28a-f shov 10a. State or than "natural", or itsms 23a or 28a-f sho Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Divorced MITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) parmit. Paga 1 and 2 should be flad within 72 Papertment of Health and Mantal Hygians. Important: If tam 27 is merked other tran "ns any injury or other traumetic event and once." 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number of FRORAH DAVIS. 7712 STONEY CASEK DE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD. Signature of Fu scheety Funeral Home M00942 2601 MOUNTAIN RD. ABADENA, MO. 21122 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENCEPHALOBATHY ANOXIC ease or condition Medical Due to (or as a consequence of Examiner SEIZURE DISORDE Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a nunsection of cartificata ba sxacutad that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical 68760 attanding physical distribution of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfe IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To this Hospital or Attending Physician: Tha law raquiras thet tha daath within 24 hours aftar daath.

To the Funeral Director: Aftar this cartificata has baan signad by tha attai complataly filled in by tha funaral diractor, page 2 should ba datechad for i in the past 12 months? 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, RES PIRATORY 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 21 No of Vital BB 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Division 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO041284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE WASHINGTON MEDICAL CENTER CAPARROS RAYMUNDO 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 2012 Year Carol Eleanor Saros Sept. 14 10:19 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mt. Airy Kline Hospice House Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) **Director** 386-42-5318 1 M 2 S F 70 Jan. 5,1942 Michigan Usual Residence of Decedent within 72 hours efter death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1405 Hunting Horn Lane 21703 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, à 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1960–62 1 ☐ Yes 2 ANo Specify. Completed Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor 12 Soap Manufacturer other Ith and Mental Hygie 27 Is marked other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin John Leppek Irene Schefka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 Is Anna I. Devine / daughter 1405 Hunting Horn Lane Frederick, MD 21703 Department of Health Important: If item 2 any Injury or other t other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hinal Journey Crematory 9/20/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Aneral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THETATIC BREART CANCER Physician/ MONTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a considuence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed siclan and burlal-trans that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the burla Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Ho Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 27 q ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 🗌 No Yes 2/ 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 67 Other (Specify) 1 Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.
Funeral Director: After thi etely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Tione 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

32. Registrar's Signature

BRIAN M, O'CONNOR MO

31. Date filed (Month, Day, Year)

501 W, SEVENTA 8TI

FRESERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEMPTEMBERT4,20012 8:49A Barbara Jean Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death SAINT JOSEPH MEDICAL CENTER BALTÍMORE TOWSON Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec. 12, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours **Director** 219-34-1957 1 M 2 X F 74 1937 Maryland Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Cockeysville 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10309 Greenside Drive 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amportant: of the traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) N/À Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ames Brown Bertha Viola Unger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 Lawndale Road Finksburg, MD 21048 Sharon Α. Green/Daughter Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 17. Dulaney Valley Memorial Gardens Sept. 2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Signature of meral Service Lisensee 22. Name and Address of Facility Lemmon Funeral Home of Dulane 10 W. PAdonia Road Timonium, Dulaney Valley MD 21093 Inc. Flagle Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death AORTIC ANEURYSM Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use es the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on d title 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)
HA, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 CHIDI EKEOCHA, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 18,2012 Physician/ September Gisella Simon 5:30 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number Funeral 6 Sex If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Country) Romania Hours (Month, Day, Year 070-42-0467 Director Tune Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maruland Montgomery Rockville. 1 Yes 2 X No 10 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6111 Montrose Road, 20852 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates the Me i al 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Seelfreund Ilona Lazar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5416 Kirkwood Drive, Bethesda, Maryland 20816 Emery Simon - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Garden of Remembrance 09/20/2012 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death MYOCARDIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an • Hospital or Attending Physician: The law 124 hours after death. • Funeral Director: After this certificate has E page 2 autopsy perform death? 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: ဥ 1 Tyes No No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending work 1 🗌 Yes Investigation 2 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 20061096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSIE ROAD PA A

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ()9 2012 Jennifer 02:45 p^M Scheps Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium <u>Stella Maris Hospice</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) 230-23-1540 **Director** 1 M 2 X F 45 Yrs. 09/23/1966 MD 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 🕱 No Baltimore Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 33 Timbershed Court 21053 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturom any injury or other transmission." 1 Never Married 2 X Married 21215-0036 1 Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Department Of Elementary/Secondary (0-12) College (1-4 or 5+) Budget Analyst Homeland Security Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Opstad Kathleen L1ovd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua P. Scheps, Husband 33 Timbershed Court Freeland, MD 21053 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/17/2012 Hilltop Svc. Corp. Towson, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as Luwg Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Cancel Approximate Interval Retween Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops Hospital or Attending Physician: The 2 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No 26. Place of Death (Check only one) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and State Registrar XDHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 2012 9:55 Patricia Ann Sawyer 09 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Gilchrist Hospice Center Columbia</u> Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) Director 1 🗆 M 2 🗀 F 264-74-6516 68 Florida Yrs 05/16/1944 Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director X□ Yes 2 □ No MD Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14590 Triadelphia Mill Road 32056 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) **Business Owner** Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Nicholas Saunders Betty Jane Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Saunders / Brother 14590 Triadelphia Mill Road, Dayton, MD 32056 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place permit. Page Department Important: It injury 4 Donation 5 Other (Specify) 9/17/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ULLES Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a Examiner weeks cov Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury month attending physician and I for use as the buriel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon#1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Day Year 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Nis 2 🗆 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniun work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 21201 ber 16, 2012 cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

3

32. Registrar's Signature

6701

D. Md 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER Day 16, 2012 SAPPERSTEIN JULIUS 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) Director 578-03-2202 1 □XM 2 □ F 100 04/05/1912 MD Usual Residence of Decedent show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be by Funeral death with 14 COBBLER COURT 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xyes 2 No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify. Completed 3 X Widowed 4 Divorced WHITE Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) id Mental Hygiene, marked other tha 12OWNER RESTAURANTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAPPERSTEIN LOUIS BESSIE UNKNOWN Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS SAPPERSTEIN/SON 2008 BURDOCK ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WORKMEN CIRCLE CEM. 09/19/2012 BALTIMORE, MD 21. Si / Jury of Funeyal Service Lic sase 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Ceath Ph_sician/ Demention disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Examir burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director. After this certificate has t autopsy 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗆 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St. Scite 4/05 Towson MD 21204 701 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 06-2011

State

2012

SEPTEMBER 13,

SCHREIBER

GERARD

ERNESTINE WRIGHT, M.D.

31. Date filed (Month, Day,

2300 DULANEY VALLEY ROAD, TIMONIUM, MD

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 14 Physician/ SKOWRONSKI IZABETH 11:19 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 195-20-9016 1 M 2 X F 86 Jan. 8, 1926 Pennsylvania Usual Residence of Decedent should be filed within 72 nous and and Mental Hygiene.
I show Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show arked other than "matural", or items 23a or 28a-f show arked other than "matural". 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 N. Hickory Avenue 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married ٤ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Registered Nurse</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Ment. Important: If item 27 is marken any injury or con-Anna Mae Tobias Stefan George Marcin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Maryanna Skowronski / Daughter</u> 512 N. Hickory Avenue, Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn.: 9-18-12 Bel Air, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: **esn** 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ō in the past 12 months?
1 Yes 2 No Day be detached the 9 Unknown g 🗌 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2. No 3 Probably 4 Unknown cate has been sig r, page 2 should t Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 SEPTEMBER 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

VOI

32. Registrar's Signature

800 ORLEANS STREET BALTIMORE MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH G931 9/20/2012 WS
State of Maryland Department of Health and Mental Hygiene 20 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:59 AM eckmber 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death It More If Under 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex . Age (In yrs. last birthday) If Under 24 Hrs. Funeral Year 1 M 2 D Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Nes 2 No althmore andalistour 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 33 items ? permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? Completed by 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify lack 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 20/2012 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fu eral Service Lic Name and Address of Facility Howell Heights 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as landiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) phulu Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 140 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

10 State

the

0

(Month.

certifier

29a. Certifier

(Check only one

29b. Signature and tit

maltha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my online, date and place, and due to the cause(s) and manner stated Conditying Nurse prantitioner: To the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated Conditying Nurse prantitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Conditying Nurse prantitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Conditions are considered.

70076

29d. Date signed (Month, Day, Year)

29c. License number

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy Narcissa Poore Tufts 9:40 pm September 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12001 River View Road Prince George's Fort Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 578-34-5029 Director 1 □ M 2 🛣 F 102 July 06, 1910 South Carolina ams 23a or 28a-f shov r must be notified at fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12001 River View Road 20744 U.S.A. ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify White. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Church, Organist & Musical Director Year or Dates Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Musician of Health and Mental Hygi item 27 is marked other other traumatic event, f Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Poore, Sr. Pearl Mignon Payseur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Richard T. Poore - Nephew Four Sunset View, Asheville, North Carolina 28804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō **Ξ** 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
John's Episcopal
Church Cemetery ö Department of Important: If any injury or once. 09/21/2012 Ft. Washington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Arteriosclerotic Heart Disease Medical **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Yes 2 No in the past 12 Day Year Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify, Hospital 2 💢 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: 3 🗌 Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier una D35206 September 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

William T. Tanner, M.D.,

2012

31. Date filed (Month, Day, Year)

SEP 2 0

11701 Livingston Road, #101, Ft. Washington, Maryland 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 201^e2 Scott Tanenbaum Sept 9:45P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 036-48-3483 1 ☑ M 2 □ F 49 Oct. 27,1962 Illinois or 28a-f show 10a. State 10b. County or than "natural", or Items 23a or 28a-f sho 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Germantown 1 Yes 2 XNo MD Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 20723 Crystalhill Circle Apt. J 20874 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. ş within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Landscape 12 Landscape Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If Item 27 Is reary Injury or other 2006. မ Sondra Barbara Press Jacob Tanenbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Church St. Lovettsville, VA 20180 <u> Michelle Krysztofiak /sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🙀 Cremation 3 🗆 Removal from State Final Journey Crematory 9/20/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ se or condition Hepatitis C Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. | Part II. Other significant conditions contributing to déath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy perform Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)HOSDICE 1 Tyes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063195 Sept. 16, 2012 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Steven Wilks, MD 6001 Muncaster Mill Rd Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 SEP 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year LASALLE ROGER VAUGHN SEP 2012 5:35 Medical 4a. Facility Name (if not institution, give street and number) WALTER REED Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL MILITARY MEDICAL CENTER MONTGOMERY 8. Date of Birth (Month, Day, Yea 11-05-23 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Months Hours Country) 437-14-7661 Director 1 MM 2 □ E 88 Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Port Royal 1 ¥ Yes 2 ☐ No Beaufort SC 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 29935 2406 Sgts. Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. African ð 1 Never Married 2 M Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4 or 5+) NA Elementary/Secondary (0-12) Gunnery Sergeant Marine Corps. 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lizette Cotton Vaughn William Roger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2046 Sgts. Drive Port Royal, SC. 29935 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau 2046 Sgts. Drive Catherine G. Vaughn-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗎 Removal from State 09-26-12 Beaufort National Beaufort, SC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician/ END STAGE DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE TO THRIVE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exam The law requires that the death certificate be executed MALNUTRITION attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Efetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day by the 9 Unknown P.O. been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy After this certificate 1 ☐ Yes 2 X No 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No |2 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) ne Hospital or Attending P. 24 hours after death. E Funeral Director: After the 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No eral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, MOIANAOP53261A SEP 19 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENER

Registrar DHMH 17 Rev 06-2011

10

32. Registrar's Signature

BETHESDA, MD 20889

BARBARA A. COOPER, MD, FACP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Semplember 12:25 PM Son 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner County of Death Maryland Georges outhern rince 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) curity Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 227-50-6597 Days Min. (Month, Day, Year) Director 69 1 M M 2 D F Virginia er then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince 1 Yes 2 No emple 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4022 St 20748 LYONS within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1015/61/65 Year or Dates. 1 ☐ Yes 2 ➡No 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Computer Zerox lechnician Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Menta Importent if item 27 is marked to you highly no other traumations. illie Wilson liola Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn 6903 Wilson-Sister Eagleton Lane Fort Washington Maryland 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 122/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility Chinn Funeral Service 21. Signature of Funeral Service Licenses, Robert B 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 605 S. Shirlington Road Arlington, Virginia 22206 Immediate Cause (Final Priysician/ 1.0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the under 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 🖾 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA Manner of Death

Natural

Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 08 242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 2 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18 2012 4:35F Physician/ Irene Catherine Woods Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Sykesville Fairhaven If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours 220-22-2893 Director 1 M 2 XF 01/20/1927 Iowa 85 show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Sykesville Carrol1 Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 7200 3rd Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify. White 3 Widowed 4 Divorced Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) 2Yrs. Elementary/Secondary (0-12) Mortgage Banking Banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Richard Alfred Woods Daisy Hook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5215 Stonemill Ct. Sykesville, Md. 21784. Ralph Woods (Son) Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State All County Cremation 09/19/2012 Sykesville, Md. 4 Donation 5 Other (Specify) 21. Signature of Furery Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final End Physician/ saus disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E der unconying Examine Due to (or as a consequence of) Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death the a g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 2 Accident Investigation I Director: A 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 | only one) 29b. Signature and title of September 19, 2012 4849

100

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd Eldersburg MD 21784

State 31. Date filed (Month, Day, Year)
Registrar

aar) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 Physician/ September Warianka 0410 Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 146-42-1026 **Director** 1 X M 2 🗆 F 61 Poland 07/23/1951 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Branchburg Somerset NJ 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 08876 10 Paddock Court u.s.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status rmed Forces? Black, White, etc þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Systems Analyst Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ည Maria Wasiczko Semen Warianka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 10 Paddock Court, Branchburg, New Jersey 08876 Margaret Warianka - Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Andrew's Cemetery 09/18/2012 Bound Brook, New Jersey 4 Donation 5 Other (Specify) Funeral Serv 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) signed by the a ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? 2 No Yes 2 X No of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 X No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending Division 24 hours after death.

Funeral Director: Aft letely filled in by the fur 1 \square Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 7 to the 29b. Signature and title of certifier 29c. License number D70622 September 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore. MD

21287

Jennifer Kanakry, M.D., 1800 Orleans Street,

SEP 2 0 2012

32. Registrar's Signature

DHMH 17 Rev 06-2011

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Virginia Ward September 2012 12:03 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockspring Village Harford Forest Hill 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 216-16-9073 1 ☐ M 2 🔀 F Yrs. 90 29, 1922 Maryland Aug. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Forest Hill Maryland Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 USA 1 Colgate Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) age 1 and 2 should be filed int of Health and Mental H t: If item 27 is marked ott 18. Mother's Name (First, Middle, Maiden Sumame) 2 John Carroll Murphy Pearl Alithea Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1113 Saddleback Way, Bel Air, Maryland 21014 Janet C. Beane / Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removatirom State Donation 5 (Other/Specify) Air Memorial Gdn 9-20-2012 Bel Air, Maryland ature of Fund 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition TTUR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed? Yes & N 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) Assisted 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Living 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P 732255 Sepsenber 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Do. 615 W. MARILA Be/11/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 SEP 20 Registrar

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of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ATRICIA Physician/ Month YOUNG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TRANSITIONS YKESVILLE HEALTH CARE 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Days Months 121-28-7612 77 Yrs. Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director Md. Carroll Sykesville 5 10e. Street and Number 10f. Zip Code 23a Funeral 21784 7309 2nd Ave. Sykesville, Md. "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) Milton Sylvester Young 19a. Informant's Name/Relationship (Type, Print) Gail Jones(Guardian) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser Immediate Cause (Final Physician/ 51 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Pregnant at time of death ed by the a detached f 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Matural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie D57722 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARDSON M-D. EUNAW State

2. Date of Death 3. Time of Death 6:15 P M EFTEMBER 17 2012 4c. County of Death CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) N Y 06^{Man#}/^{Pay}Year N.Y 10d. Inside City Limits 1 XYes 2 ☐ No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business Industry None 18. Mother's Name (First, Middle, Maiden Surname) Anna C. Merecka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Stoner Ave. Westminster, Md. 21157. 20c. Location - City or Town, State Springfield Cemetery 09/19/2012 Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1838 GREENE TREE ROAD # 300 PILLESVILLE MD 21208 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

30120

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 2<u>012</u> Month Linda Lee Yingling Sep. 18, 1:04 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 219-56-5944 **Director** 1 □ M 2XXF 61 Yrs Nov. 1, 1950 Maryland Usual Residence of Decede show at 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Carroll 1 Yes 2XX No Manchester 10e. Street and Number č 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Completed by Funeral 4944 Grave Run Rd., P.O. Box 522 21102 U.S.A. ral", or items 2 Examiner mus death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2XXMarried Page 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes aXX No Specify If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Specify: White if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Carroll County Board Elementary/Secondary (0-12) College (1-4 or 5+) Secretary of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Schaeffer Catherine Staub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 Dennis W. Yingling (Husband) 4944 Grave Run Rd., P.O. Box 522, Manchester, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 0 Ali^{empter, cremator, or other place)}
Ali^{empter, cremator, or other place)}
& Chapel Department Important: If any injury or 9/21/2012 Manchester, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune Service License 22. Name and Address of Facility Eckhardt Funeral Chapel, 3296 Charmil Drive, Manchester, MD 21102 Part. Enter the disease, or complications that bock, or heart failure. List only one cause on e . Enter the disease, or complications that caused the death. Do not enter the mi e of dying, such as card Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day 9 Unknown 9 \ Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 1 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death, I Director: A ed in by the fi ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the title of certifier 29b. Signature aj 30. Name and ad

State Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Webster Ervin Zantt 10:15 a^M 9 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 920 Augusta Ave. Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Country) 10:15am Director 216-28-4215 1 X M 2 🗆 F 1/30/1931 MD 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified 28a-f MD N/A Baltimore 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 23a 920 Augusta Ave. 21229 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō ģ 1 Never Married 2 Married 1 Yes 2 No Specify: "natural", 3 Divorced Specify: Black Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Security Guard 910 Security Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius C. Zantt Alethia Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Zantt-Wife 920 Augusta Ave. Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Opnation 5 Other (Specify) Garrison Forest 19/24/2012 OwingsMills. MD Signature of Funeral Service I 22. Name and Address of Facility icense March F/H-East 1101 E. North Ave. Baltimore, 21202 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. sh te Cause (Final Onset and Death Physician/ STAGE CARDIAC or condition ing in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ō Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown 1 | Yes 2 L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has death? Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Other: မှု 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Naturai 5 Pending 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one To the within 7 29d. Date signed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HARLES 20: ALLEN 2012 september 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 12,1935 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Ane (In vrs. last hirthday) **Funeral** Months 1 XM 2 □ F 213-32-1009 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Baltimore 1 Yes 2 No Director MD Baltimore notified 28a-f 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or must be r 7243 Bridgewood Drive 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mertial Hygiene. It I flem 27 is marked other than "natural", or file iny or other traumatic event, the Medical Examiner iny or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

Cable Pluger (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Western Electric 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Allen Sr. Bertha Pasek ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Allen /son 4509 Red Leaf Court Ellicott City MD 20b. Place of Disposition (Name of cemeter, crematory or other place)
Bayview Crematory9/22/12 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once, 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Calut Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 815 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 1 ract Many Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed neumonia physician and is the burial-tranresulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760¢ Medical as IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Munknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an renal stage e has b 21 No 2 🗌 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗷 Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ပ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: I Director: After to in by the funer 1 Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🗁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified ٥ september 18, 2012

State Registrar

SEP 2 1 2012 Seven S. Sank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a & branch Pervision C932 10/02/2012 JH amend #19a & branch Pervision C932 10/02/2012 JH amend Mental Hygiene -9,11,12,15,16a & J. 17, 18,20a - 2 Reg. No. 2 For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 РМ 2:48 September Stanley Francis Abramek Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Atlantic Avenue 8. Date of Birth unk (Month, Day, Year) ocial Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 203-01-8788 Director 1**X** M 2 □ F 91 3-27-1921 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland must be notified at **Funeral Director** Salisbury 1 Yes 2 No MD Wicomico 10f. Zip Code 21804 10e Street and Number 10g. Citizen of What Country? 5 202 Atlantic Ave. 23a items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 110 K 14 Race - American Indian Examiner Black, White, 0 by YXX Yes 2 If Yes, Give Year or Dates White 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Specify. 3₩Widowed 4 □ Divorced "natural" Completed the Medical Decedent's Usual Occupation UNIC (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Lineman -unk11 unk Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည Michael Abramek Regina Sun Personal Rep. 1007 Grant Aveling or Sallsbury 19a. Informant's Nama/Belationship (Type, Print)

Debra Ellen Hickman

Edward Walter Hill er, Mit or **21/80 (**te, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State Wicomico Memorial Pk. 10-03-2012 4 ☐ Donation 5 ₺ Other (Specify) in state Salisbury, Maryland 22. Bounds of Fun Home 705 East Main Street Salisbury,MD Naylor 21201 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 No within 24 hours after death.

To the Funeral Director: At Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check To the only one 29b. Sidnatur 29d. Date signed (Month, Day, Year) 5 8 V nd address of person who completed cause of death (Item 23a) (Type, Print) Name 0 filed (Month, Day, Year) State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 212-28-8560 1 M 2 X F 4/13/1932 80 Marvland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore Maryland Parkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21120 U.S.A. 1 Musket Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ≥ hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Yes Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Account <u>General Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ၉ permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 Is marken any Injury or other traumatic e Margaret W. Heyman Charles C. Dasch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkton, Maryland 21120 1 Musket Court David J. Andrzejewski / son Saltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Sacred Heart of Jesus 9/22/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Foneral Service Lie 1050 York Road Towson, Maryland 21204 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANC disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate sician and burial-transit or Attending Physician. The law requires that the death certificate be executed Cause (Disease or injury that initiated events Box 68760 Due to (or as a consequence of): resulting in death) Last Physician/Medical as the IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month 5 Other (specify) Day signed by the at d be detached for 1 Yes 2 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 2 🗹 No 1 Yes 25. Was case referred to medical Be B 26. Place of Death (Check only one) Other: 1 Yes 2 10 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1-Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar EP 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death rist olumbia Howard enter Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. Days 217-6809 **Director** 1 0 M 2 0 F 1950 mari June 6, 28e-f sho 10a. State 10b. County Pege 1 and 2 should be filed within 72 hours efter death with the Meryland rel", or Iteme 23e or 28e-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5216 Horence US 2 121 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4 or 5+) owell 12th of Heelth end Mental Hyg Item 27 is merked othe other treumetic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aller ည illiam Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lenyan Aller onthel AUC, Guyn ran 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of Important: If It eny injury or o 1 Burial 2 Cremation 3 Removal from State Woodbine Journe 4 Donation 5 Other (Specify) 21. Sign were of Funeral Service Licenses 22. Name and Address of Facility mg, 21229 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physiciani LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 24 hours after death. From this certificate hes been signed by the ettending physicien end etten in the funeral director, page 2 should be deteched for use as the buriar-transit etely filled in by the funeral director, page 2 should be deteched for use as the buriar-transit Exam Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 PNO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No HOSPICE Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the date and place. and the firms, date and place, and due to the date and place. only one 29b. Signature and title of confile 29c. License number 29d. Date signed (Month, Day, Year) D72139 plember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q. 6336 ABBAS CEDAR LANE COLUMBIA MD 21044 31. Date filed (Month, Day, Year) SEP 2 1 32 Registrar's Signatu State 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #8, per fh, g931 9-21-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth Stopp Physician/ BROWN LEE 2 8 12 1:32 PM MARGARET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death KLINE HOUSE mT AIRY FRODERICK . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1915 172-22-9245 Months Days Hours **Director** 1 M 2 Z F 97 Yrs MD. April 27, Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HD. CARROLL SYILLS VILLE Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral VIRGINIA AVE 21784 USA 7114 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 \square Never Married 2 \square Married 1 Yes 2 No Specify Maryland 21215-0036 If Yes, Give Year or Dates Black Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) COUCATION SCHOOL TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BROWN CORA GROOMES JOHN WESLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 si Health a WILLIAM S. HUDSON JR, 7114 VIRGINIA AVE SYKESVILLE MD Important: If item 2 any injury or other I Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 ō 1 Burial 2 Cremation 3 Removal from State RESTHAUGN USM. CHEODY SOT 24, 2012 PRESCRICK MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLIN'S FUNERAL HOME 21. Signature of Funeral Service Licens ollers Sund. 110 WEST SOUTH ST PREDERICK MD 21101 23a. Part 1. Enter M disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) the attending physician Completed by Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, parton 5 ion 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an filled in by the funeral director, page 2 performed Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Kline Hollo 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51643 9-21-12 CAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederics no 21702 Thomas Then sen Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Thomas Burrell 7:01 p_{\bullet}^{M} September 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a 1613 Appleton Street Raltimore **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **№** M 2 🗆 F Months Hours Min. (Month, Day, Yea 2-21-1939 Days 216-36-6990 73 **Director** M Usual Residence of Decedent s 23a or 28a-f show ust be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director n/a MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1613 Appleton Street , and Mental Hygiene. ' is marked other than "natural", or items 23: raumatic event, the Medical Examiner must f 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 😾 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: African-AMerican 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sherwin Williams Paint Co. Mixer Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George W. Burrell Annie Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 1613 Appleton Street, Baltimore, MD 21217 Lena Burrell Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Louden Park Cemetery 9-21-2012 Baltimore, MD 21. Signature of Fureral Se 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition 110 Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months
1 Yes 2 No detached for Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? s after death.

Director: After this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be the within 24 hours after des To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signati 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mon(h, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Ruby Mae Bullock 7:00Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death n/a 4601 W. Northern Parkway, Apt. 412 Baltimore 9. Birthplace (State or Foreign Country) T7A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours (Mphth, 294y, 1930) 226-34-2275 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 W. Northern Parkway # 412 21215 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify: African-American Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Aide Balto. City Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Ments fitem 27 is marked r other traumatic e Emmanuel Cole Donothy Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon R. Bullock/daughter 7409 Allmont Road, Balto. MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important; It any injury or 9-26-2012 Garrison Forest Veterans Owings Mills, MD 22. Name and Address of Facility Sign of uneral Servi Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a Part 1. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensive Immediate Cause (Final Physician/ CARDIOVASCULAR disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FRENLIPIDE MIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 724 MAIDEN CHOICE LANG SUITE ZOY BACTIMORE, MO. 21229

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G932, 10/12/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BIGGUS SOPHIA Physician/ CLARA Month 5007 3:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK SPRUCE CT. 200 If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 218-30-9338 10/02/19 1 🗆 M 2 🗾 F Director 78 MD. 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified FREDERICK FREDERICK 1 Yes 2 ☐ No MO. 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 200 SPRUCE 21701 USA Department of Health and Mental Hygiene. In protant: If item 27 is marked others any injury or others. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COOK NURSING FACILITY TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ TANIE HERBERT ROLLINS JESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19357 PARADSE MANOR OR HAGERSTOWN MD 21742 CLARICE R. SWANN (DAY) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) SEPT 20, 2012 PREDEXICK MD. 4 ☐ Donation 5 ☐ Other (Specify) SUNNYSIBE UMCCEM. 22. Name and Address of Facility GARY L. ROWINS FUN. HUNE 21. Signature of Funeral Service Licenses Kollis FLEDERICK MD sun SOUTH ST 110 WEST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ MOM disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death ed by the al 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 5 Pending injury Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number Nephrologist D005428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Freducile MD 405 West 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Raymond Barry	'	1- For State Registrar	State	of Maryland		ment of <i>icate of</i>		id Mental I	Hygiene	Reg.	No.	201	2 3013
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JR. 8:35 A.M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAHIMORC OWS rist TOSPICE OA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) **Director** 215-07-0264 1 M 2 □ F MD -22-1920 ir than "netural", or items 23e or 28a-f show the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21630 12. Was Decedent Ever in U.S. Armed Forces?

1 ₺ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed ITUNIT 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DONOT use retired) 2 should be filed within 72 hend Mantal Hygiena. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Haalth item 27 1 rylon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p permit. Paga 1 d Department of H Important: If ite eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗗 Other (Specify) I NURN TIMONIUM JOSEPL N ZANNINO 21. Signature of Juneral Service Licensee 134/to Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ NUQS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and I for use as the buriel-transit Exami The lew requires that the death cartificate ba axacuted Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav signed by the at d be detached for 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director, After this certifical complately filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o ure and title of certi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) balthusle 11050 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bethen DRINE 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Healthcare Baltimone enesis 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 84 Yrs. 250-40-1614 Director 15/1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10h County 10c. City, Town or Location 10d Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Wes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6801 STURBRIDGE DRIVE USA 21234 Was Decedent of Hispanic Órigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify 2 Specify: BLACK 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEKEEPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaineu George PEARLINE EADDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gainey (Brother RICHARY 1014 MARLAW Drive. BALTIMOVE, Md. 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/24/12 BALTIMORE, Md 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCIVICES 21. Signature of Funeral Se wice Licensee 14.01553 4905 York ROAD. BACTIMORE, MARYLAND. 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or se a c equence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Box 68760, 5 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Lectopic pregnancy in the past 12 mop Day Year Month 5 ☐ Other (specify) P.O. ☐Yes 2012No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Division of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Seath (Check only one) Hospital: 1∐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manney f Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 atural 5 Pending investigation death. 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 9/18/2012 of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State SEP 2 1 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Day 19 Physician/ 11:45 P M 2012 Linda Grace Beal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Care 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-54-1597 1 □ M 2 💆 F 06/30/1951 61 Usual Residence of Dece 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No **Baltimore** MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 USA 125 N. Broadway, 2nd Floor 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Midowed 4 ☐ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) John Hopkins Sr. Patient Coordinator 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be fill.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve **Peggy Sterling** Linwood W Lee, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8402 Charles Valley Court, Towson, MD 21204 Peggy Lee / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/25/2012 Hanover, MD Cremation Ctr Of MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Waughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE MYELOMA Physician/ a cars disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 has page 2: within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospile 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending 1 ☐ Yes 2 ☐ No м Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature September 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Sr AMON CHAMES MD 6701 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Emma Lee Bloyer SEPTEMBER 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | April 116, 1944 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 215-46-5813 Country) MD Director 1 M 2 X 68 Item 27 is marked other than "naturai", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 21220 10e. Street and Number 10g. Citizen of What Country? 6726 Mallard Road Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Burton George Ogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6726 Mallard Road Balto. MD 21220 Bloyer, permit, Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau Jerry Bloyer/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Hollt Hill Cemetery 9/21/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service 300 MAce Ave. Balto. MD 22. Name and Address of Facility Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ neumonia disease or condition ZweekMedical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 1 ☐ Yes 2 ☑ No |요 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles, St. s Signa 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O9 SUSAN BONDI 00:45 AM HURD 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE, MARYLAND 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Director 215-48-2405 1 □ M 2 💢 F 59 February 19,1953 Baltimore, Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1651 East Belvedere Avenue Apt. 415 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Horse Trainer <u>Equestrian</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eliot P. Hurd, Sr. Marian Handy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen H. Schuman (Sister) 1276 Townbrook Crossing Charlottesville, VA 22901 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Evans Funeral Chapel—Bel 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel. & Cremation
16924 York Road Monkton, Manylar
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line.

Immediate Cause (Final disease or condition

SEPTIC SHOCK 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Monkton 16924 York Road Monkton, Maryland 21111 Approximate Interval Between Onset and Death SEPTIC SHOCK Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dive to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68766 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown PANCREATIC MASS LIKELY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No မ 1 🗌 Yes 1 Dempatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, usite and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES000 areles 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 5601 LOCH RAVEN BLUD BALTIMORE, MD 21239 JERUSHA NAIDOO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ William K. Bowen Sr. 03:20 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis multimedical Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8 Date of Birth Days Hours (Month, Day, Year)
May 14, 1925 216-14-8122 Director 87 1 XM 2 - F Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 28a-f Baltimore Parkville 1 Yes 2 Xo ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 3323 Parktowne Road 21234 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Firefighter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Bowen Ethel Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
808 Lynch Terrace Fallston, Maryland 21047 Michael J. Bowen-20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 8 20c. Location - City or Town, State Department of I Important: If ite any injury or ot September Evants Function of the place) Chapel - Bel Air 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22, 2012 Forest Hill, MD Signature of Funeral ervis Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ a Metastatic Stage four Lung Cancer months Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Michelle & Kalender, CRNP AD97104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

Michelle E. Kalender CRNP Genesis Multimedical Center 7700 York Rd. Towson, MD 21204

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Edward Barrett Medical 4a. Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore City Security Numb If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) 215-24-7519 83 Director 1**X**XM 2 □ F Feb. 7, 1929 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes aXX No Arbutus Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4839 Carmella Drive United States 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No1946 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XX Married ğ Maryland 21215-0036 1 ☐ Yes 2√√No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) N/A Elementary/Secondary (0-12) Telephone Company 12th Cable Splicer/ **Installer** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frances Jones Edward Barrett 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4839 Carmella Dr., Arbutus, Maryland 21227 Georgia Anne Barrett/ Wife Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any Injury or ot 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Prk. Sept. 24, 2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fyheral Service Licensee 22. Name and Address of Facility AMBROSE FUNAERL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 M01456 aller Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 4RRed | してインナイナール Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 D been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Tes 2 XNo ☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 (MR)0 မှ 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JX Buthore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Robin Cummings Sep 11, 2012 6:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 4401 Chalet Court 8. Date of Birth (Month, Day, Year) Dec 5, 1978 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex Days Hours Min. 1 □ M 2 🗗 F **Director** 214-92-5678 33 or 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🖁 Yes 2 🗆 No **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21206 U.S.A. 4401 Chalet Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examiral Injury or other traumatic event, the Medical Examirans Injury or other traumatic event, the Medical Examirans Injury or other traumatic event, the Medical Examiration Injury or other traumatic event, the Medical Examiration Injury or other traumatic event, the Medical Examiration Injury or other traumatic events. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diana Brown Robert Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Suntop Court. Baltimore, MD 21209 Valerie Collins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Sep 18, 2012 Windsor Mill, Md. King Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Kespirator Medical Due to (or as a consequence of): Examiner Gravis asthenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE esn yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 X No detached 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome Anhphospholipid 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Erythematosis 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has I autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 2 🗷 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 2012 30. Name and address of person who comp Kovell

M DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number or Location of Death 4c. County of Death Examiner TOPKINS 11a N/A Social Security Number g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 573-56-8461 Director 1 X M 2 □ F 68 March 28,1944 California item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Texas Travis Austin 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7705 Shadyrock Drive 78731 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. \$ 1 ☐ Never Married 2 🌠 Married Saltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 【 No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Software Sales Software Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jean Yuill William H. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Clark / Wife 7705 Shadyrock Drive, Austin, Texas 78731 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. : 4 ☐ Donation 5 ☐ Other (Specify) 09/21/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition Medical resulting in death) Du to (or as a consequence of Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 11/10 မြ 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leans St. Baltimere MD. 21287 ARATH

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09:39AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Lake Drive 8. Date of Birth
(Month, Day, Year) Year If Under 24 Hrs. last hirthday 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🗹 Director Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes, specify Cubar Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ₩idowed 4 ☐ Divorced K Completed lack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "I DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Domestic ome maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 homAs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr E, daughter HUMOSE 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Jourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 27,2012 21. Signature of Funeral Service Licensee Service 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) unkoun Examiner Atherosclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): unknown Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed this certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🔀 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 A Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Af completed filled in by the fu ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1200614 82 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bushiva I-AL-Azzawi, MD, 6830 Hospital Dr-1 32. Regis Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Came Frank 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OFBALTIHORE NIA BALTIMORE 8. Date of Birth (Month, Day, 0102 7. Age (In yrs. last birthday) 85 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 1 X M 2 □ F 243.40.276 Director Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Bultimore Kandallstown 1 ☐ Yes 2 📈 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ō or than "natural", or items 23a on the Medical Examiner must be Funeral 4205 Paran 21133 USA Koad Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other thraumatic any injury or other traumatic and other traumatic and other traumatic and other traumatic onstruction McCabb ConstructionCo. Brd grades Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VIOLa Brown lonard Caine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 6409 Fembank Baltimore MD 21214 (Ichele) T. Avmstego 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 2728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIONYOPATH Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760Ce physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the a detached f 9 | Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv 1 ☐ Yes 2 🗙 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2" No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural
2 Accident work? 1 🗌 Yes 2 🔲 No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 071264 09-19-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1350 VAN DUSEN RD SUITE 220 LAUREL, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18, 2012 Suet - Hing 1:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Veeceen Place Assisted Living Burtonsville Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 277-78-3141 **Director** 1 M 2 X F 96 June 2, 1916 China Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Burtonsville 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 14318 Duvall Hill Court 20866 Hong Kong within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: Asian Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Not available Wong Not Available permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita S. Cheung / Daughter 9354 Penrose Street, Frederick, Maryland 21704 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State September 20, 1 Burial 2 X Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Signature of Fur Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 ketter annu M01305 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between 1 Day Death Immediate Cause (Final Pnysician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure 5 Years Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (snar a consequence of): 5 Years the Hospital or Attending Physician: The law requires that the death certificate be executed Cerebral Vascular Accident burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months? 1 Yes 2 4 Pregnant at time of death Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of cate has autopsy performed? death? certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living 1 Yes 2 🗓 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death

To the Funeral Director, A
completely filled in by the Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitione f To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year, MID D41828 September 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clara Chan, M.D. 9801 Georgia Avenue, #337, Silver Spring, Maryland 20902

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ink Cook		State of Maryland / Department of H 1-For State Certificate of D			2012	3014				
Physici	an/	1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Year 1011 by							
edical Exami	ner	1 PAPA	City, Town, or Location of Death	September :	5, 2012 4c. County of Death	1011 hrs				
			rentwood		Prince George	s				
Funeral			Under 1 Year If Under 24Hrs Months Days Hours Min.	_ / `	MM/DD/YYYY) 9. Birth Foreign	nplace (State or				
Director		05/32 0488 1XM 2 F // Yrs.	Days Hours Willing	04/21		ntry) // /				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			<u>'</u>	10d. Inside City Limits				
A	ō	MD PRINCE GEORGES COHAGE (144			1 Yes 2 No				
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	of. Zip Codie	10g.	Citizen of What Count	try?				
with the us 23a c		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	20122 ecedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	an Indian, Black,				
death or item	Funeral	1 Yes 2 No	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	100%				
rs after ural", miner	ē	or Dates:	s 2 No specify: Isual Occupation (Give kind of w	ork done 16	Specify: O 6b. Kind of Business/in	dustry				
72 hou n "nat	To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life, DO NOT use retir							
5-0036 led within Hygiene. lother than		11th Pain	, -, -	(F) (AF 1 II - AA	UNKNO	OWN				
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle Mai	(I) Mor	CTON				
21; hould b and Men is mar			dress (Street and Number or R	tural Route Numbe	r, City or Town, State,	Zip Code) 20603				
and 2 s ealth a tem 27		OFEPHANIE (REWS) Mugitae Signal 20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date 2	Oc. Location - City or T	PF, MD own, State				
DOCE ages 1 nt of H nt: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other p	HORSEN 091	15/2018	Silver	SOOMA M				
Baltimore permit. Pages 1: Department of H. Important: If it injury or other t		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility	was	3 HINGTO	NDE				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	IN AND SONS	3635	EADS ST	Approximate Interval				
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiova		respiratory arrest,	, shook, of ficalt	Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
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recuted 1 and - transit		events resulting in death) Last Due to (or as a consequence of): d.								
O, e be exe ysician a	edical	UNPENDED								
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and should be detached for use as the burial transi	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal decedent	eath 3 Ectopic pregna	ncy	23d. Date of delivery Month Da	y Year				
Sox 6876 leath certificate e attending phy for use as the I	Physicia									
O. B. at the de I by the tached f		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?				
s, P.O. irres that the signed by d be detacl	Completed by	Chronic renal failure; Chronic obstructive pulmonary disease; C	hronic alcohol abuse	1 Yes	2 No 3 Proba	,				
ords aw requi as been 2 should	prior to co	24b. Were autopsy findings available prior to completion of cause of								
tal Rec			1 ✓ Yes 2 No 1 ✓ Yes 2							
Division of Vital Records, tal or Attending Physician: The law requir 1s after death. al Director: After this certificate has been sted in by the funeral director, page 2 should!	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check of DoA Other Nursing		sidence 6 🗸 Other:	Scene				
n of \ding Phy. After tl funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how	injury occurred					
Sion Attend death. ector:	Certification:	1 V Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, far	1 Yes 2 No	20f Langting (Chro	at and Number or Dura	I Davida Number City				
Division To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	et and Number or Rura e)	Route Number, City								
Div Hospital or 24 hours afte Funeral Dis) and manner as stated									
To the within 7 to the complet	Medica	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.								
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		ed. Date signed <i>(Monti</i> September 6, 201:					
_ ,	ł	30. Name and address of person who completed cause of death (Item 23a)			·					
21		Patricia Aronica-Pollak MD. Assistant Medical Examiner 900	W. Baltimore Street, B	altimore, MD 2	21223					
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				7				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland Department of Health and Mental Hygiene 20 | 2 AMEND ITEM#20a-certificate of Beauty 9/27/2012, WS 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month 7_M 3 CLARK A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITA SPRING 8 HOUSGOMERY If Under 24 Hrs If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 246-62-456 1 M 2 M F North Carolina 09.09.1930 Usual Residence of Dece 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 WYes 2 □ No SPRIN WD UBR MONTGOMER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code FAIRLAND 090 101 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify XX Widowed 4 Divorced BLUAC Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) healthcare 12 CNA o 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOSPITAI 1500 porest CROSS GLENRD. SILVER SPRING MD 20910 HOLY 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) in state lincoln Crematory 9/25/2012 Brentwood, Md. 22. Name and Address of Facility

The Lincoln Funeral

Brentwood, Md 20/20 f Fyeral Service Licensee Nay 21. Signature hone, 340 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RENAL PAILURE disease or condition resulting in death) Due to (or as a consequence of) SPIRIATORY Dus to (or as a consequence of) PSIS E Due to (or as a consequence of)

Ph. sician/ Medical **Examiner**

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Hospital or Attending Physician: Division of Vital

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Records, P.O. Box 68760

Physician/

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Department of
Important: If it
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Baltimore, Maryland 21215-0036

Examiner

other traumatic event, the Medical

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Sequentially list conditions Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23d Date of delivery

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Certificate:

Medical

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 27. Manner of Death

IF FEMALE:

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 9 Unknown

Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 24a. Was an

2 No 3 Probably 4 Unknown

autopsy perform Yes 26. Place of Death (Check only one) Other:

Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes

MD 50016

25. Was case re examiner?	eferred to medical
	2 No

Natural

(Check

only one 29b. Signature

Accident

Suicide

5 Pending Investigation 6 Could not be

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury

4 Nursing Home 5 Residence 28c. Injury at work? 2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

SPRING

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier

Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signald (Month, Day, Year)

SHUER

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print MAI FORE

Certifying Nurse Practitioner: To the best of my knowledge,

HHED 31. Date filed (Month, Day, Year) SEP 2 1 State

200 32. Registrar's Sig

Registrar

P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, 22 per fh g932 I0-5-I2 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 17 2012 Physician/ Gertrude 2', 45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Future Care - Pineview Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) June 14, 1933 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Co*untry)* Virginia Director 1 □ M 2√□ F 79 577-48-0403 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💂 No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20010 USA 110 Irving St NW 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed 3 ⅓ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 nursing assistant healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1672 Montello Ave NE; Washington, DC 20002 Edward Holland - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from Stat 4 Donation 5 18 Other (Spe Resurrection Cemetery 9-25-12 Clinton, Md. uneral Service Licensee 22. Name and Address of Facility State Capitol Mortuary 1425 21. Signature of Washington, Maryland Ave 20 IDC. 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Enysician** disease or condition resulting in death) raunic Medical Due to (or as consequence of): kaminer enebra NEUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of After this certificate has been signed by the attending physiclan and funeral director, page 2 should be detached for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Succeed at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day 1 ☐ Yes 21 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure Respiratory 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ᅙ 1 Tyes 2 🗐 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after usa...

To the Funeral Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Pine viceo 20735 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 2 Registrar

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			For State		State o	of Mary			ment of F icate of L		and N	1ental Hy		20	12	3	011.
		7	Registrar 1. Decedent's Name (F	First, Middle, L	ast)			Cerum	Cale Of L	- Calli		2. Date of De	Reg. N		16	3. Tim	ne of Death
П	Physicia Medic		Martin Edw	ard Co	ffman							o 9 ^{lonth}	16	Day 20) <u>ř</u> *2 ^r		08 P M
	Examin	er	4a. Facility Name (if no 9604 Haven	Farm		,			City, Town, or Perry I		of Death			c.County altin			ity
	Funeral Director		5. Social Security Num 214-11-001		Sex 1 X M 2 □ F	7. Age (In)	rs. last birth	Mo	Under 1 Year onths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da)	9. Birth Cou		ate or Foreign
			Usual Residence of D	Decedent	1 📤 M 2 🗆 F	26	Y	rs.				11/05/	1985	5	MD		
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	with t	Funeral	9604 Haven	Farm	Rd., Apt	. В			2112	28			_	SA		, Ki y i	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 3 Widowed 4		If Yes, Giv	rces? 2 X No e	n U.S.		Decedent of H s, specify Cuba Yes 2 X No			cify Yes or No- Rican, etc.)	-		k, White,	can Indiar etc.	٦,
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Maryland 21215-0036	led wit Hygie other ent, th	45	17. Father's Name (Firs)		Mus	sical	Direct		er's Name	e (First, Middle,		sex n Surname			
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Man	shoul raums		19a. Informant's Name		, , , ,		- 1	_	,			l Route Numbe				Code)	
	and 2 Health tem 2		Dianne Cof 20a. Method of Dispos		Mother	20	20 Db. Place of			one D		Fallsto Date		MD 21 Location -		own Stat	ρ
m _O	Page 1 nent of int: If i		1 🔀 Burial, 2 🗆 4 🗆 Donation 5			State	cemetery	, crematoi	ry or other plac			0/2012			-		
Baltimore,	permit. Departn Importa any inju		21. Signature of Fune				202 112	22. Na	me and Addres	ss of Facilit	y Sc	himunek	Fu	neral	Hon	ne,	
	⊕ ⊕ e o	Н	23a. Part 1. Enter the	disease or co	molications that o	aused the	death Dong					., Bel		, MD	2101		
334	Physician/		shock, or heart fa Immediate Cause (Fin	ailure. List only	one cause on ea	ch line.	hil	A AA	O day	g, 3001 a3	cardiac c	respiratory at	11001,				Between Ind Death
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09,	ate be chysici the bu	dica			d												
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 moi 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?		Birth 2 🗀 nant at time	Fetal death		topic pregnanc ner (specify)	у				23d. Dat Mo	e of deliv	rery Day	Year
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ion	tendin leath. or: Aft the fur	Certificate:	2. Accident	5	on (한약//6/	2102	1/20	31	work 1 □		No E	Suic.d	e k	oyh	ans	int	
Division	lor At after o Direct	Cert	4 Homicide	determine	28e. Place	of Injury - Ang, etc. (Spe			actory, office		- 1	28f. Location (S City or Tov Notting	yn, Stat	e) 40	r or Rur	Route of	m Rd
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this of completely filled in by the funeral directors.	Medical	29a. Certifier 1	Certifying Ph	ysician: To the b	est of my kr	nowledge, de	eath occur	rred at the time	, date and	place, ar	d due to the	ause(s)	and mann	er as stat	11 2 8 ed.	
	the H thin 24 the Fi	Me	(Check 2 Notes only one) 3 29b. Signature and title	Certifying Nu	miner: On the bas irse Practitioner	To the best	of my knowl	edge, deal	th occurred at the	ne time, da	te and pla	ce, and due to	the caus	se(s) and m	anner as	stated.	
	7		29b. Signatale and title	7116	m ?	10.34	4.		29c. License			<	29d. D	ate signed	(Month,	Day, Year)	212
	5v		30. Name and address	of person who	completed caus	e of death (Item 23a) (T)	rpe, Print)	(7)	the c	1.0.1)0 M	ر ه <u>د م</u>	2100	3	700	ار ا
	Stat Registra	e	31. Date filed (Month, E	Day, Year)	, , , ,	egistrar's si	gnatur	Nes .	.41 -6.		101	-					
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ary Crivello		State of Maryland / Department 1-For State Certificate			and	Mental Hy	_	Don No	201	2 30148	
Physici	ian/	1. Decedent's Name (First, Middle,Last)					2. Date of De			3. Time of Death	
ledical Exam		MAKI CKIVELLO					Month Septemb	er 16,	Year , 2012	0630 hrs	
		4a. Facility Name (if not institution, give street and number)	4	-		cation of Death		- 1	c. County of Dea		
		Franklin Woods Nursing home	\perp	Roseda		W.L. 1. 0.01	la a		Baltimore Co		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday)		If Under 1 Months	Days	If Under 24Hrs. Hours Min.	1		Fore	irthplace (State or ign	
Director			Yrs.				JUNE 2	26,1	937 ^c	ountr MARYLAND	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocatio	on						10d. Inside City Limits	
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with tl 18 232 19 1900	┏	1402 LANCELOT DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was		212 3 of Hispa	3 / nic Origin? (Spe	cify Yes or N	0-	USA 14. Race - Ame	rican Indian, Black,	
eath v	Funeral	1 Never Married 2 Married Armed Forces?	If Ye	es, specify C	uban, M	flexican, Puerto F	Rican, etc.)		White, etc.		
ifter d 17, nr	by Fi	3 X Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X	No s	specify:			Specify:	WHITE	
ours a		15. Decedent's Education (Specify only highest grade completed) 16a. Dece				(Give kind of wo		16b.	Kind of Business		
6 .72 h cal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	ig illo	St OI WORIII	y III e. D	O NOT ase real	, a	В	ALTIMORE	E CITY	
5-0036 led within 72 Hygiene. other than	Completed		\L	SECRE					AW FIRM		
21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medical		17. Father's Name (First, Middle, Last)			- 1	Mother's Name (·		
112 Id be Menta narke	o Be	LEROY HEIDERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ilina	Address (HELEN V			JNN City or Town, Stat	e Zin Code)	
0 77 40 75	ြိ			,		E DRIVE			D. 21221		
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 i injury ar ather traumai		20a. Method of Disposition 20b. Place of Dis	posit	tion (Name			Date		Location - City o		
Baltimore, Dermit. Pages 1 at Department of Hee Important: If ite		1 Surial 2 Cremation 3 Removal from State crematory or			тты	,, l	2012	_	AT MTMODI	, MD	
it. Partme	100	4 Donation 5 Other Specify: MOST B 21. Signature of Funeral Service Licensee 22		ame and Ad			-2012		ALTIMORI	OME, INC.	
E P P I						DOL			, MD. 21		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the	e mode of d	ying, su	ch as cardiac or	respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and	
Evaminor		Immediate Cause (Final disease a. Cardiac tamponade complicating	g m	yocardia	linfaro	ction				Death	
or condition resulting in death) Due to (or as a consequence of):											
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876 ifficat ng phy is the	ξ	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2	Feta	al death	3	Ectopic pregnan	СУ	23	3d. Date of deliver Month	Day Year	
Box 68760, e death certificate be the attending physic ed for use as the burned for use	Physician/M	past 12 months? 4 Pregnant at time of death 5		er (Specify)							
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Records, P.O. Box 6876 The law requires that the death certificate are has been signed by the attending phy age 2 should be detached for use as the t	by P	Part II. Other significant conditions contributing to death but not resulting in the	he un	nderlying ca	use give	en in Part I.		_		the cause of death?	
S, P.C puires that an signed I	pe	Pneumonia, diabetes mellitus				-					
ords w requi as been s should	Be Completed						24a. Was auto	psy	prior to	utopsy findings available completion of cause of	
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tal tian: certifi	36 (25. Was case referred to medical examiner?				Death (Check or					
al dire	욛	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient							ence 6 🗸 Othe	er: Scene	
Division of Vital Records, rail of the taw requires and red death. In our death. In our death. In pirector. After this certificate has been sited in by the funeral director, page 2 should be a feel in by the funeral director, page 2 should be a seen of the funeral director.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	of Inj		_ `	at Work? 2	8d. Describe	how inj	jury occurred		
SiOl Attendeath death octor:	cati	2 Accident Investigation						· • · · · · · · · · · · · · · · · · · ·		De to North City	
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	street	, factory, on	nce build	aing, etc.	or Town,		and Number or K	ural Route Number, City	
Cospita l houn unera ly fille		29a. Certifier	2011-	ad at the ti-	o dete	and place and d	ue to the er	100(0) -	nd manner as sta	ted	
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. The Funeral Director: After this certifit completely filled in by the funeral director,	Medical	one) 2 Medical Examiner: On the basis of examination and/or investi									
To Tin 1	Med	and manner stated. 29b./Signáture and title of certifier		29c. Li	cense n	umber		29d.	Date signed (Mo	onth, Day, Year)	
		(9/1, 11/1)			.C.M.				otember 18, 2		
. /		30, Name and address of person who completed cause of death (Item 23a)									
OV		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W	. Ba	altimore 9	Street,	Baltimore, N	/ID 21223				
S	tate	31. Date flect (Month, Day) (141) 32. Registrati Signatura									
Regis		DEL ST TOIL DOWN									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland		ırtment of F tificate of L			giene Reg. No. 2 (012	30149
	Physicia Medic		1. Decedent's Name (First, Mid	gle, Last)					2. Date of De Month		Year	3. Time of Death
~~ <u>~</u>	Examin		4a. Facility Name (if not institution Morningside				4b. City, Town, or Baltimo:		h		ty of Death	e
	Funeral Director		5. Social Security Number 216–20–9033		ge (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th		lace (State or Foreign
	and show at	or	Usual Residence of Decedent 10a. State 10b. Cour	tty	10c. City, To	own or Loc	ation				10	Od. Inside City Limits
	Marylis 28a-f	Director		timore	Balt:	imore	,			150		1 🗌 Yes 2 🗶 No
	with the 23a or ist be n	Funeral D	10e. Street and Number 1400 Wiltwyck	Rd.			10f. Zip Code 21209			10g. Citizen o	f What Count	try?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ N 3 ☑ Widowed 4 □ Divorce	12. Was Decedent Armed Forces? 1 Yes 2		If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ace - America ack, White, e fy: W	
Baltimore, Maryland 21215-0036	Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specif								Business Ind	ustry		
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and	be filed ental Hy ked oth ic even	To Be	17. Father's Name <i>(First, Middle</i> Marion	e, Last) Blak	e			18. Mother's Na	me (First, Middle,	Maiden Surnar	_{ne)} Stapf	
Aary	should and M is mar raumat		19a. Informant's Name/Relatio	nship (Type, Print)			g Address (Street a	and Number or Ru	ıral Route Numbe		State, Zip C	ode)
re,	1 and 2 of Health item 2 other t		Diane Gassawa	·	20b. Place	e of Dispos	Wiltwyck sition (Name of		Itimore,	MD 212 20c. Location		vn, State
timo	t. Page tment o tant: If jury or		1X Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Othe	on 3 Removal from State r (Specify)	Loud	on Pa	rk Cemete	ery 9/2		Baltimo		· .
Ba	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funera 3620 Wilkens Ave., Baltimore, MD											
7	Physician/ Medical Examiner	iner	23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									Approximate Interval Between Onset and Death
09/	law requires that the death certificate be executed ras been signed by the attending physician and a 2 should be detached for use as the burial-transit	edical Examiner	cause, Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):						
O. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pregnanc Other (specify)	у			ate of deliver	ry Day Year
rds, P.C	equires that teen signed brould be deta	by	Part II. Other significant cond	itions contributing to death I	out not resultir	ng in the ur	nderlying cause giv	en in Part I.		Yes 2 ☐ No	3 🗌 Prob	e cause of death? ably 4 Unknown
ž	The ate I	e Completed	25. Was case referred to medic	al			26 Pla	ace of Death (Che	1 \(\text{Yes}		were autop prior to com death? 1 \square Yes 2	sy findings available npletion of cause of
VIta	hysicia this cert al direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 - ER/		3 DOA Othe	r: 4 Nursing F	lome 5 Resid	dence 6 🗆 Ot	her (Specify)	
o uc	nding F ath. r. After ie funer	icate		stigation		b. Time of injury	28c. Injury work' M 1 🗆	rat ? Yes 2 □ No	28d. Describe h	now injury occur	rred	
Division of Vital	al or Atte s after de I Directo d in by th	Certificate:	3 Suicide 6 Cou 4 Homicide dete	Id not be rmined 28e. Place of Inj building, et		, farm, stre	et, factory, office		28f. Location (S City or Tou	Street and Numi vn, State)	ber or Rural I	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medica	(Check 2 L Medica	ng Physician: To the best of I Examiner: On the basis of ng Nurse Practioner: To the	examination an	d/or investi	gation, in my opinio	n, death occurred	at the time, date a	and place, and d	ue to the caus	se(s) and manner stated.
	To t To t		29b. Signature and title of certif	T (/1919/1/	/ W	1	29c. License	number		29d. Date sign	ed (Month, D	ay, Year)
	51		30. Name and address of person	on who completed cause of control of the Management of the complete of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	death (Item 23)	a) (Type, Pr	int)	157	. / / / / / / / / / / / / / / / / / / /	E (100 T	Vi (13%	MANZING
	Stat Registra		31. Date filed (Month, Day, Year,		ar's Signature	h	40					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 DAVENPORT FRANCES 6:45PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BACTIMORE HARBOR N/A NEDSTAR HOSPITAL If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 212-34-1622 **Director** 1 □ M 2 👿 F 82 Virginia Dec. 28, 1929 Usual Residence of Decede 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland 0denton 1 Yes 2 No Anne Arundel ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 492 St. Barbara Lane 21113 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", Specify: 3 ☑ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Rosa Chumley Charles Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 492 St. Barbara Lane, Odenton, Maryland 21113 Garry Davenport / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 09/20/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ SEMENTIA disease or condition resulting in death) Medical Examiner CARDIOVASCULAR YEARS ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Pregnant at time of death g Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform To the Hospital or Attending Physician; The 2 HO 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ᅆ 1 Yes 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 - Natural 5 Pending injury s after death.

I Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 \square Certifying Nurse Practitioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 129807

Registrar

DHMH 17 Rev 06-2011

State

CARCOS

31. Date filed (Month, Day, Year)

3001

32. Registrar's Signature

S. HANOVER ST.

BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 533 p 2. Date of Death Physician/ 6100 10 unnie Lee Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 62 Director 234-80-0109 1 X M 2 | F Nov 21, 1949 West Virginia 28a-f show ital Hygiene. ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA Funeral 750 Dual Hwy Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 2 🗷 No 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) graft cutter golf course permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Golden Harold Davis 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Gode) 1401 Haven Rd #T10; Hagerstown, MD 21742 Brenda Davis - wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 3 ☐ Other (Specify) in state fun ral Se 22. Name and Address of Facility State Anatomy Board An Naylor Baltimore St; Baltimore, MD 21201 655 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be until 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed chesendan7 24b. Were autopsy findings available prior to completion of cause of 24a. Was an renal autopsy performe death? 2 X 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🗙 No မ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 00632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 520 Northeru MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4 5	istrar		Ochinoate	of Death		R	eg. No.		
	Decedent's Name (First, Middle	e,Last)				2. Date of Dea Month	nth Day Year er 15, 2012	3. Time of Death 0528 hrs	
J	John Dwayer Facility Name (if not institution	n, give street and number)	4b. City, Town,	or Location of De		4c. County of Dea		
	Johns Hopkins Bayvie			Baltimore					
Director 21	19-18-1053	6. Sex 7. A	ge (In yrs. last birthday				Fore	eign Sountry) MD	
	ual Residence of Decedent 1. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
Aaryland 28a-f show any 1 at once. ector 001	MD Bal	timore	Arbutu	ıs				1 Yes 2 X No	
the Maryland a or 28a-f sh tiffed at once Director	. Street and Number		•	10f. Zip Code		1	0g. Citizen of What Co	untry?	
or items 23a or 28a-f sho must be notified at once. Funeral Director	826 Sulphur Sp Marital Status	ring Road	t Ever in II 6 12	. Was Decedent of F		227	USA	erican Indian, Black,	
or items 23 must be no	Never Married 2 X Ma	rried Armed Forces		If Yes, specify Cub			White, etc.	erican indian, black,	
by F		rced If Yes, Give Year or Dates:	1	lo s <i>pecify</i> :		Thite			
2 hours	5. Decedent's Education (Spec Elementary/Secondary (0-12)	ify only highest grade co	durin	edent's Usual Occup ng most of working li			16b, Kind of Business	s/Industry	
5-0036 ed within 72 hours lygiene. he Medical Exam Completed	8	0	,	ecial Del	livery C	arrier	Postal S	Service	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	Father's Name (First, Middle, I	•				me (First, Middle, I	•		
D 2121 rould be fi ould John Pau1 Dway Informant's Name/Relationsh		19b. Ma	ailing Address (Str			ne Bonhoff nber, City or Town, Stat	te, Zip Code)		
MD d 2 sho lith and lith and 27 is numeric	Mary Jane Dway	er / Wife	82	e Sulphur	Spring		outus, MD 2	21227	
20a.	Method of Disposition Burial 2 Cremation	3 Removal from Si	ate crematory o	sposition (Name of co or other place)		Date	20c. Location - City of		
t. Page trant:	Donation 5 Other Spe Signature of Fugeral Service L	ecify:	Baltimor				Baltimore ineral Home		
Bal Departimble Impo	Signature of Funetal Service L	icensee					Arbutus, M		
i ityololali	Part I. Enter the disease, or of failure. List only one cause of	complications that caused on each line.	I the death. Do not en	ter the mode of dying	g, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
	nediate Cause (Final disease condition resulting in death)	a. Head and Neck						Death	
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
if an cau	ny, leading to immediate use. Enter Underlying Cause	Due to (or as a cons	equence of):	·		-			
S ever	sease or injury that initiated into resulting in death) Last	Due to (or as a cons	equence of):						
tox 68760, eath certificate be executed eath certificate be executed for use as the burial - transit or use as the burial -	UNPENDED	dAMENDED							
b. Box 68760, the death certificate be executed the death certificate be executed by the attending physician and cohed for use as the burial - transport of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the d	EMALE:	23c. If yes, outco	me of pregnancy				23d. Date of delive	TV	
687 Sertifica ding p ding p ta as th	Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death 3	Ectopic preg	gnancy		Day Year	
Box 687 death certification is death certification be attending part of for use as the hysician//	Yes 2 No 9 Unkr		time or death 5	Other (Specify)			Ĺ		
	t ii. Other significant condition				-	-	bacco use contribute to		
Records, P.(The law requires that firate has been signed to page 2 should be det Completed by	Hypertensive atheroso	lerotic cardiovascu	ılar disease, Chr	onic obstructive	pulmonary	1 Yes	2 No 3 Pro	utopsy findings available	
of Vital Records, g. Physician: The law requir wher this certificate has been s meral director, page 2 should n: To Be Completee	disease					autop	sy prior to	completion of cause of	
tal Recting The certificate ector, page Cor	Was case referred to medical			26.Plac	ce of Death (Chec	1 ✓ Yes	2 No 1 Y	es 2 No	
Vital hysician: ysician: director, o Be (examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸 ER/Outpat		IOthor -		Residence 6 Othe	er:	
fon of Vital seath. Seath. After this certifule in the funeral director, attention: To Be (attention: Manner of Death	28a. Date of Inju (Month, Day.) Sep 14, 2012	ury 28b. Time (ear) 2300 hrs		ury at Work?	28d. Describe h Subject fell of	now injury occurred			
Division o pital or Attending ours after death. Filled in by the func Certification:	Accident Invest	igation	njury - At home, farm, s	, '	Yes 2 No			ural Route Number, City	
Division of At ours after defer a Direct filled in by	Suicide 6 Could determ	not be		aroot, radiory, office	building, etc.	or Town, S			
	Certifier 1 Certifying Phy	vsician: To the best of m					• •		
To the Howithin 24 h within 24 h To the Fellow Completely (Cope)	2 Medical Exam Signature and title of certifier	finer: On the basis of exa and manner stated.	mination and/or invest		n, death occurred	at the time, date a	and place, and due to the 29d. Date signed (Mo	``	
299.	Signature distribution continer				.M.E.		September 15, 2		
1 2									
OX / 30.1	Name and address of person v	tho completed cause of c	leath (Item 23a)						
97 / [Name and address of person v Donna M. Vincenti, MD Date filed (Month, Day, Year)	Assistant Medic	, ,	00 W. Baltimor	e Street, Balt	timore, MD 212	223		

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Thomas Charles DeWees 8:00P M Sept 19 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Catherines Nursing Center Emmitsburg
If Under 1 Year | If Under 24 Hrs. Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1**⊠** M 2□ F Months Days Hours Min 212-42-7947 Director 67 9-23-1944 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Martical Example or other traumatic event, the Martical Example or other traumatic event, the Martical Example or other traumatics are not the martical examples. MD Director Frederick 1 ☐ Yes 2 No Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 Pleasant Acres Dr. 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2💢 No Specify: Specify: White Ś 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Superintendant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Jahnigen Harry DeWees 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Pleasant Acres Dr., Thurmont, MD 21788 Joan A. DeWees-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 9/24/12 Winfield, MD 22. Name and Address of FacilityFletcher Funeral & Cremation 21. Signature of Funeral Service Licensee 254 E. Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗀 Unknown 9 Unknown Part الاجتار Part الإجتار Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case refered to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 av 10 Date filed (Month, Day, State SEP 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ D199 . DOTM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hospital 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. Director 1 M 2X F Maryland 12/03/1933 78 2 should be filed within 72 hours efter death with the Meryland the end Mental Hygiene.
27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 U.S.A 1657 Vincent Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 Yes 2 No Specify: Black Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 1th Grade College (1-4 or 5+) N/A Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva unk Leonard Diggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3516 Lyndale Ave., Baltimore, MD 21213 permit. Pege 1 end 2 st Depertment of Heatth e Importent: If Item 27 is eny injury or other tre Alicia Thomas(Granddaughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
t. Zion Cem. 09/14/12 Baltimore, MD Mt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License පැරතුළත්∕්ර්ර්ණිං ්ජිමේwn. Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 weluc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENO-Stage (ardiomyopaThy Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): cate has been signed by the ettending physicien end ; pege 2 should be deteched for use es the burlei-transit Hoepital or Attending Physicien: The lew requires that the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate 2 🗌 No 1 Yes in 24 hours efter death.

he Funerei Director: After this certific pletely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number ns Rajapathe MD D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baitmore MD 21209 NS Rajapar SE MO 2835 5 203 Smith A 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State

SEP 2 1 2012

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23e perPHYS, G932, 10/8, 2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 16, 2012 Physician/ 5:00 рм Helen Faye Deitz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Halethorpe 1310 Stevens Ave. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yes 225-30-5886 Director 1 □ M 2 🗚 F 86 FEb. 7, 1926 Virginia Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Halethorpe Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21227 1310 Stevens Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maxfield Carlie Sykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Stevens Ave., Halethorpe, MD. 21227 Donald D. Deitz (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 9/21/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service 3620 Wilkens Ave., Baltimore, MD. 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ oronou disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Examiner if any, leading to immediate cause. Enter Underlying s a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death been signed by the should be detached 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has page 2 death?
1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 0 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred hours after death. uneral Director: After injury 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN CHOICE W, BALTO, MY 21228 RADGER 716 GARRY M 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 9-Physician/ Anna Genivieve Elliott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Ritchey Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 213-30-0057 1 ☐ M 2 🖫 F 79 April 02,1933 Baltimore, Marylan Vrs permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any highly or other traumatic exceptions. 10a. State 10b. County 10c. City, Town or Location Director Baltimore 1 X Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral United States 21206 4917 Sinclair Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 💆 Married Š 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White Completed 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Essex Community College Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Jacobs Paul S. Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4917 Sinclair Lane, Baltimore, Maryland 21206 Oral Elliott (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State September 21, Parkville, Maryland Parkwood Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation

800 Farford Road Parkville, Me

23a. Part 1. Enterine disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear viailure. List only one cause on each line. Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Aura Physician cancer disease or condition Medical resulting in death) Due to (or as a compound uence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or, ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown フレルイ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12006476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 2 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_		For State State Registrar	e of Maryland		irtment of H tificate of D			giene Reg. No.	2012	30157
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Robert F. Ellingsen					2. Date of Dea Month 09		2012 Year	3. Time of Death 11:20 P M
	Examin		4a. Facility Name (if not institution, give street and Atlantic General Hosp			4b. City, Town, or Berlin		ath		ounty of Death	-
	Funeral Director		5. Social Security Number 6. Sex 1 124 M 2 0	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Day, Year) Country)		
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc			10 1, 0 = ,		1	0d. Inside City Limits
	ne Mary or 28a-1	Director	MD Worcester 10e. Street and Number		Ucear	City 10f. Zip Code			10a. Citizer	n of What Cour	1 Yes 2 K No
	h with th	Funeral	111 136th Street			2184			USA		
980	init. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. internet of Health and Mental Hygiene wortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at it.	by	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. ed Forces? Yes 2 \sumbox No s, Give or Dates. Army	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 👿 No	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	in 72 hou e. nan "natu Medica"	Completed	15. Decedent's Education (Specify only highest grade composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of th	lete <i>d)</i> ge (1-4 or 5+)	(Give F life. D	ent's Usual Occupa ind of work done d O NOT use retired)	ution uring most of w	orking/			
d 21	led with Hygien other th	l as l	8th 17. Father's Name (First, Middle, Last)		Foren	nan	18. Mother's N	Name (First, Middle,	-		Concrete
Maryland	uld be fi Mental narked natic ev	욘	Hans E. Ellingsen					I. Battag			
Mai	d 2 shou alth and 1 27 is n er traum	Ì	19a. Informant's Name/Relationship (Type, Print) Rose M. Caudell - Sis	ter				Rural Route Numbe Jarretts			
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal 4 □ Do ation 5 □ Other (Specify)	from State Ce	metery, cren	sition (Name of natory or other place Cremator	i	Date / 20/2012		tion - City or To	
Baltii	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce.	- 0 -)	21. Signature of Funeral Service Licence	ACI	22	. Name and Addres	s of Facility	Schimunek Rd., Bel	Funer	al Hom	е,
	Physician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition			r the mode of dying		iac or respiratory ar		ue	Approximate Interval Between Inset and Death
	Medical Examiner		resulting in death)	ue to (or as a conseque	ence f):	(- (
	ed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ie to (or as a conseque	ence of _j .					-	
	cate be executed physician and s the burial-transit	al Exa	that initiated events C.	ue to (or as a conseque	ence of):						
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/ital	sician; certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Yes Hospital:	1 √ Inpatient 2 □ I	=B/Outnation	Othe	er:	heck only one)	donos 6 🗆	Othor (Specifi	
n of ∿	ding Phy h. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 Pending		28b. Time of injury	28c. Injury work	at	28d. Describe			/
Division of Vital Records,	To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:		Place of Injury - At hor building, etc. (Specify)	ne, farm, stre		11	28f. Location (S City or Tov		lumber or Rura	Route Number,
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	To th Within	2	29b. Signature and title of chiffier	M	>	29c. License		,		signed (Month,	
	IDV		30 Name and address of person who completes Nicholes Boroduli	cause of death (Item	23a) (Type, F	Print) Crock	ed blech	ING FELL	septe.	Iskud	Delgavy
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2012	32. Registrar's Signati	par	V		7)	/

DOR-4/2/1935 DOD: 9/16/2012 TOD: 2320

ELLINGSEN, ROBERT F.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 19 Year 2012 FLAX 01:00AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death COPPER RIDGE SYKESVILLE CARROLI . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Days Min (Month, Day, Year) Director 212-30-1863 1 🗆 M 2 🗓 F 87 03/14/1925 POLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No MD CARROLL SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 710 OBRECHT ROAD 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) je 1 end 2 should be filed within 72 t of Health and Mental Hygiene. If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) RESEARCH T. ROWE PRICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ERNEST KAPLOW MARSHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 DEVONSHIRE DRIVE, BALTIMORE, MARILYN FLAX/DAUGHTER MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Department of h Importent: If Ite 1 X Burial 2 Cremation 3 Removal from State ò injury 09/20/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) LUBAWITZ NUSACH ARI of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Domentia Priysician/ disease or condition resulting in death) ea/s Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending physic for use es the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifica letely filled in by the funeral director. 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year,

) _____State Registrar

DHMH 17 Rev 06-2011

MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

filed (Month, Day, Year)

SEP 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street City, Town, or Location of Death **Examiner** 4c. County of Death venve timore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8 Date of Birth Min. (Month, Day, Year, Director 1 ☑ M 2 ☐ F 76 Yrs. 30-1936 27 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No timore 10e. Street and Numb 10f, Zip Code 10g. Citizen of What Country? Funeral 3823 21215 15A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Divorced 5/acl Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arrene 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shound Health and Item 27 is n 19b. Mailing Address (Street and Number or ral Route Number City or Town, State, Zip Code) 2823 HimpreMD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If Ite eny injury or ot 1 Burial 2 Cremation 3 Removal from State Gimor MO 4 Donation 5 Other (Specify) Greene Fyneral Services Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Approximate Interval Between prostate (ancer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transif Cause (Disease or injury certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
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DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician/ SEPT 2012 9:15 SHIRLEY Μ. **GROSS** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DISTRICT HEIGHTS 1874 ADDISON ROAD SOUTH PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days SEPTh. Dal 20071935 76 1 □ M 2 🗓 F WASHINGTON, DC Director 240-54-2655 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD PRINCE GEORGE'S DISTRICT HEIGHT'S 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1874 ADDISON ROAD SOUTH 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 X Married Yes 2 XNo 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: BLACK If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) GOVERNMENT PERSONNEL ASSISTANT 1YR is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ JAMES HOWARD JESSIE WHITAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) l and 2 sh of Health a item 27 i STERLING J. GROSS/HUSBAND 1874 ADDISON ROAD SOUTH DISTRICT HEIGHTS, MD 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASH. NAT'L CEMETERY 09-19-2012 SUITLAND, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER RD. HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Carse (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ GASTRIC ADENOCARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760arsigmaPhysician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 XNo has been signed by the second 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has b autopsy performed? Yes 2 X No page death? 2 🗌 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2**X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 Yes Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, Funeral Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie 29c. License number

State

31. Date

Registrar
DHMH 17 Rev 7/2009

THU NGUYEN MD 6104 OLD BRANCH AVENUE TEMPLE HILLS, MARYLAND 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

D58686

SEPTEMBER 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

John Dieter Gobir	1	SIGI - For State Registrar	e of Maryland		ificate of D		iu ivientai r		teg. No.	201	2 3016
Physiciar Medical Examin	1/	 Decedent's Name (First, Middle, L 	ast) John D. Gop	ing		-		2. Date of De Month Septemb	ath Day er 13, 2	Year 2012	3. Time of Death 1831 hrs
	ľ	4a. Facility Name (if not institution, of 16001 Shady Grove Roa	give street and number)			City, Town, o	r Location of Dea		4c.	County of Death	
Funeral Director		5. Social Security Number 6.		e (In yrs. las		Under 1 Ye			,	968 Cou	
' any	ı	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location						10d. Inside City Limits
ne Maryland or 23a-f show any fied at once.	ğ	Maryland Montgo 10e. Street and Number	mery			n Poto	mac		10a. Citiz	en of What Coun	1 Yes 2 X No
h the Ma	<u>e</u>	15245 Dufief Dri	ve)878			ed State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiera Matural", or Items 33a or 28a-f sho Important: If item 27 is marked other than "aatural", or Items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Marri	12. Was Decedent Armed Forces? 1 Yes 2 ed If Yes, Give Year		If Yes, s		ispanic Origin? (:			14. Race - Americ White, etc. Specify:	white
hours afte	ted by	3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12)	or Dates:	. ,	16a. Decedent's U	Isual Occup				nd of Business/I	
oo36 vithin 72 ene. er than	Completed		4		Compute	r Prog					Contractor
215-C	မ္တ	17. Father's Name (First, Middle, La Henry Goping	st)				18.Mother's Nan Ger	ne (First, Middle, trud Hes		Surname)	
Should I and Mer		19a. Informant's Name/Relationship Gertrud Goping /			_	•	et and Number of Drive,				Zip Code) land 20878
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatite event, the Medical pages.	İ	20a. Method of Disposition 1 Burial 2 X Cremation	Removal from St	20b. Plate Mon	ace of Disposition ematory or other r Tgomery matorium	(Name of collace)	emetery, Se	ptember		ocation - City or	Town, State Maryland
Baltin permit. Pa Departmet Importan injury or	t	4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	easee	M0130	22. Name Rober	and Addres	ss of Facility Fur	eral Home	/Rock	ville. In	
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on	each line.		Do not enter the m	node of dying	g, such as cardiac	or respiratory ar	rest, shoo	ck, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Intraoral Shotgu Due to (or as a cons								Deads
	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):							
ted Insit	E ((Disease or injury that initiated events resulting in death) Last									
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	dical	UNPENDED	dAMENDED	_						. حدد برس	
5876(srtificate fing phys	an/Me	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		2 Fetal d	leath 3	Ectopic preg	nancy		Date of delivery Month D	ay Year
Box (death or he attenced for use	Physician/	1 Yes 2 No 9 Unkno	wn 9 Unknown	time of deaf	tn 5 Other	(Specify)					
P.O.	2	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the unde	rlying cause	given in Part I.	l		se contribute to to No 3 Prob	he cause of death? ably 4 Unknown
ords, w require us been si should b	Completed							24a. Was	psy	prior to c	opsy findings available ompletion of cause of
Recort The la ificate har, page 2		25. Was case referred to medical				26 Plan	ce of Death (Chec	1 Yes	ormed?	death? 1 ✓ Ye	s 2 No
Vital hysician hysician this cert	Ö	examiner? 1 Yes 2 No			ER/Outpatient 3		747	sing Home 5		nce 6 🗸 Other	Scene
Division of Vital Records, P.O. Box 687, pital or Attending Physician: The law requires that the death certifics ours after death. Interal Director: After this certificate has been signed by the attending pitilled in by the funeral director, page 2 should be detached for use as the	tion:	27. Manner of Death 1 Natural 5 Pending		ear)	28b. Time of Injury FOUND: 1831 hrs	· I _	ury at Work? Yes 2 ✔ No	28d. Describe Subject sh		ry occurred	
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T N N N N N N N N N N N N N N N N N N N	¥e	29b. Signature and title of certifier		^			se number			ember 14, 2	
18./		30. Name and address of person wh						D.W.			
Sta	ite	Patricia Aronica-Pollak 31. Date filed (Month, Day, Year)		ledical E	xaminer 90		imore Street,	Baitimore, N	2122 טוי		
Registr		SEP 2 1 20	12 Cenara	, B.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ SEPTEMBER Day 18 2012 **GERSUK** SYLVIA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FUTURECARE CHERRYWOOD REISTERSTOWN BALTIMORE 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) Country) Director 214-14-4567 1 🗆 M 2 🗶 F 89 06/06/1923 MD Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🏋 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 rms 23a or Funeral 4603 EMBASSY CIRCLE, #103 21117 USA "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) CLERK FINANCIAL permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) 2 ROSE LEWIS BERMAN ISRAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 EMBASSY CIRCLE, #103, OWINGS MILLS, MD 21117 SUSAN LANDSMAN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BOBROISKER BENEFICIAL 09/20/2012 1 💹 Burial 2 🗌 Cremation 3 🗆 Removal from State ROSEDALE, MD 4 Donation 5 Other (Specify) 21. Sign vure Funeral Service Lens+ 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheridenti Cardy Discase Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonare Obstmonive 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed' death? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 욘 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: eral Director: After filled in by the funer within 24 hours a

To the Funeral C

completely filled

29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 118/12 147683 Mille Tramond

MD

21117

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Owings Mills 1525 Miller

Ray mond 31. Date filed (Month, Day, Year) 2 1 2012

3 Suicide 4 Homicide

building, etc. (Specify)

28e. Place of Injury - At home, farm, street, factory, office

State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 632 RKNK Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death KNDRIN 100 FRUNDE Ane Social Security Number Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 439-22-4467 Director 1 XM 2 ☐ F 85 JULY 27, 1927 LOUISIANA perritt. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28e-f show any injury or other traumetic event, the Medical Engineer mas be notified at any injury or other traumetic event, the Medical Engineer mas be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD PRINCE GEORGE'S GLENARDEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3205 JOHNSON COURT 20706 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1966 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed BLACK Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) GOVERNMENT 2+LOGISTICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OSCAR HUNTER DAISY THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 JOHNSON COURT GLENARDEN, MD 20706 ELEANOR E. HUNTER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY 09-28-2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER RD. HYATTSVILLE, MD 20785 23a. Part 1. Enter the di. 6 su, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he int failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition 2axs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burlal-trensit attending physician end I for use as the burlal-trensit Exam Le that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate hes been signed pege 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 🗆 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \text{ Other (Specify)} 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1

Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 36 M9 12 even 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YMNYS MD HERSH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:35 PM September 17,2012 Robert William Hundertmark Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore 9226 Bellbeck Road 8. Date of Birth May 30, 1942 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Maryland 212-40-4665 1**X**] M 2 □ F **Director** 70 Yrs Usual Residence of Decedent 28a-f show 10a, State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville MD 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code ıral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 9226 Bellbeck Road 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Produce Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Ment William Hundertmark Norma Virginia Sindall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Pauline S. Hundertmark 9226 Bellbeck Road-Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Sept.20,2012 Parkville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pheumon disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Eequentlany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the burial-tran that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executifing 24 hours after death.

To the Funerat Director, After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burian! resulting in death) Last Division of Vital Records, P.O. Box 687602 Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

K. Schudi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Lelphia RD, Skitk 300 BACTO MD 21237 32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D39758

State Registrar

SEP 2 1 2012

DHMH 17 Rev 06-2011

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7PState of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ohnso aw ence Medical 4a. Facility Name (if not institution, **Examiner** Washington Social Security Number **Funeral** If Under Date of Birth Birthplace (State or Foreign Country) Months **Director** 214-35-0419 1 M 2 - F Louisiana permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Events. 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Hagerstown Washington MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 20335 Jefferson Blvd. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2X Married Yes 2 🗓 No Yes, Give black 1 Yes 2 X No Specify Specify Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 shipping & handling production worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Brown Henry Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio, Code) 20335 Jefferson Blvd; Hagerstown, MD 21740 Joelle Johnson - wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Signature of 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death asovor accident Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e. 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Day Year Pregnant at time of death Other (specify) Yes 2 No g Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 🗸 မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manuar of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examîner: On the bas Certifying Nurse Practitioner of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) Name and address of berson 31. Date filed (Month, Day, Year) SEP 2 1 State Registrar

Stephen Keene 12-06987 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 30168

		1- For State Registrar	or waryland / D	Certificate	of Death	ara monta	, ,	Reg. No.	12 0010
Physici		Decedent's Name (First, Middle,Last))				2. Date of Dea	ath Day Year	3. Time of Death
ledical Exami	ner	Stephen Keene			10.00		Septembe	er 16, 2012	0610 hrs
)		4a. Facility Name (if not institution, give 2908 Woodland Avenue	street and number)		Baltimore	or Location of [Jeath	4c. County of I	N/A
Funeral		Social Security Number 6. Sex	7. Age (In	yrs. last birthday			24Hrs. 8. Date of Bi		Birthplace (State or
Director				50		ays Hours	Min. 11/25	IF.	Country) Mary land
		Usual Residence of Decedent							
ж апу		10a. State 10b. County		. City, Town or L		0			10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show	tor	Maryland N/ 10e. Street and Number	A			nore Cit		10 0''' 115	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland test Set 1 and 2 should be filed within 72 hours after death with the Maryland in: If item 77 is marked other than "natural", or items 23a or 28a-f she in the traumatic event, the Medical Examiner must be notified at once	Director	2908 Woodland Ave	าแอ		10f. Zip Code	, 21215		10g. Citizen of What United	d States
h with t ems 23s	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cul		? (Specify Yes or No	14. Race - / White, e	American Indian, Black,
or it	Fun	1 Never Married 2 Married	1 Yes 2				20110 1 11021 1, 0101/		Black
rs afte ural",	ģ	3 Widowed 4 Divorced 15. Decedent's Education (Specify onl	If Yes, Give Year or Dates:		Yes 2 X		d of work done	Specify: 16b. Kind of Busin	
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and 2 shou lealth and h	ř	Denise A. Keene /							land 21215
e, M 1 and 2 Health fitem 2		20a. Method of Disposition		20b. Place of Dis	sposition (Name of		Date	20c. Location - Ci	
MOF ages ant of other		1 Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State	•	or other place) on Forest	lo	9/28/2012	Owings N	Mills. MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Sign ture of Funeral Service Licens	60				Stallings	1 ~	•
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Physician /http://doi.org/		23a. Part I. Enter the disease, or compli failure. List only one cause on each	h line.		ter the mode of dyir	ng, such as card	liac or respiratory am	est, shock, or heart	Between Onset and
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D.O. Box 68760, that the death certificate be executed by the attending physician and detached for use as the burial - tra	Physician/	past 12 months?	4 Pregnant at time	of death 5	Fetal death Other (Specify)	coopic pi	egilaricy	Worth	Day Teal
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Division of Vital Records, and Attending Physician: The law requires after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, s	street, factory, offic	building, etc.	28f. Location (S	Street and Number of	or Rural Route Number, City
Spital hours ineral	ဦ	4 Homicide determined	(Specify)				Baltimo	ore,MD.	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director:	Medical	one) 2 Medical Examiner:	n: To the best of my known the basis of examinate						
F wit	Me	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		(/ Autorkout)		0.0	C.M.E.		September 1	6, 2012
4	ł	30. Name and address of person who co	•				· - · · · · · · · · · · · · · · · · · ·		
X		Laron Locke MD. Assista	nt Medical Examir		Baltimore Stre	et, Baltimor	re, MD 21223		
St Regist	ate rar	S1. SE PERZIOI (h.Z. Zar)	32. Registra s Si	garle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Winifred M. Kaline PM 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore FRENKLIN Saucie Rosedale HOSPITa 8. Date of Birth (Month, Day, Year) Jan. 20, 1936 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 217-30-3671 1 M 2 X F 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location
Baltimore 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21205 1031 Spangler Way USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) Catherine Coleman 17. Father's Name (First, Middle, Last) Norman Thomas Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cutter Shark Road Baltimore MD 21229 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing 3921 Regina Hayford /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/21/12 Baltimore MD 21. Sign Jure of Fulneral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespiratory Distress 3 dsys disease or condition resulting in death) Due to (or as a consequence of) Kumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events monary Due to (or as a consequence of) resulting in death) Last IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Live Term Carlo in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown

Ph_sician/ Medical Examiner Examine Division of Vital Records, P.O. Box 68760 CL Physician/Medical

Physician/

Medical

Director

Funeral

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Completed

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MD

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

ed by the attending physician detached for use as the buria

Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Be Completed by

Medical Certificate: To

 Q_{l}

_ "	State of the death but her resulting in the didentying dade given in that in	23e. Did tobacco use contribute to the cause of death?		
Diobetes M	ellitus	1 Yes 2 No 3 Probably 4 Unknown		
		24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No		
25. Was case referred to medical	26. Place of Death (Check	only one)		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Ho	me 5 Residence 6 Other (Specify)		
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, ar iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place, and due to the cause(s) and manner state		

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21222 Deburh C. 00 6730 Hulabird 69110

31. Date filed (Month, Day, Year) State SEP 2 1 2012 Registrar

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chrisanthi 40 AM Kosmas Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner DundalK Baltimore Heritage enter If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Greece Months (Month, Day, Year) 218-58-9477 Director 1 🗆 M 2 🔀 F 93 9-17-1919 or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County must be notified at Director Baltimore MD 1 Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral Rapolla Street 21224 720 Greece if Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items any injury or other traumatic event the Madical Town 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 2 X No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) home own Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) iannouris Papanicolaou ပ Demitrios Amalia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
720 Rapolla Street Bullmore, MD 21224 19a. Informant's Name/Relationship (Type, rint) Kosmas Jam 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State Bultimore, MD 221 Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2134 WILLOW Stringed Bradley-Ashton Funeral Home P.A. Dundalk, MD2 222 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Day Pregnant at time of death signed by the at d be detached for death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to 26. Place of Death (Control only one) Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 1 2012 Registrar's Sig State Registrar

DHMH 17 Rev 06-2011

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villiam John Lo	•	1- For State Registrar	tate of Marylan		rtment o				Reg. No.	201	2 3017
Physicia Medical Exami		1. Decedent's Name (First, Mid- William John						2. Date of De Month Septemb		Year 2012	3. Time of Death 1425 hrs
		4a. Facility Name (if not institute 670 Laurel Drive	ion, give street and numb	oer)		4b. City, To Pasade	own, or Location ena	of Death		c. County of Dea Anne Arunde	
Funeral Director		5. Social Security Number 215–46–7160	6. Sex 7.	Age (In yrs. I	ast birthday) Yrs	If Under Months			,	Fore	irthplace (State or ign ^{ountry)} Maryland
any	ł	Usual Residence of Decedent 10a. State 10b. County	/	10c. City	Town or Locat	ion					10d. Inside City Limits
Maryland 28a-f show d at once.	ē		ne Arundel				sadena				1 Yes 2 No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number 670 Laurel Dri	ve			10f. Zip 0	2 11 22			tizen of What Co United S	
21215-0036 Jild within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", ar items 23a or 28a-f ah s event, the Medical Examiner must he notified at once	Funeral	11. Marital Status 1 Never Married 2 X I	1 X Yes		If Y	es, specify	Cuban, Mexican	gin? (Specify Yes or I n, Puerto Rican, etc.)			White
urs after ural", 1 miner 1	à	3 Widowed 4 D 15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates:	completed)			No specify.	kind of work done	16b.	Specify: Kind of Business	
15-0036 filed within 72 hours a 1 Hygiene. ed other than "natural t, the Medical Examin	Completed	Elementary/Secondary (0-12				ost of work	ing life, DO NOT		US	S Postal	Service
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle William J. Lo	ry, Jr.		40h Mailin		Rosa	r's Name (First, Middle	ello)	Za Cada)
MD 2 nd 2 shoul alth and M m 27 is m	욘	19a. Informant's Name/Relation Linda M. Lory			100		•	mber or Rural Route N Pasadena,		=	
and and trail		20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Removal from	State	Place of Dispos crematory or ot	her place)	•	Date		Location - City of	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other 21. Sinna re of Fune al Salvio	Specify:	Cr	ownsvil	le Ve	et. Cem.	09/18/201 Stallings	.2 Cr	cownsvil	le, Maryland
Derm Depa Injur		Mad	86 1		31	.11 Mo	untain	Road, Pasa	idena	a, Maryl	and 21122
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		Sequentially list conditions,	b Due to (or as a co								
A B ig	Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								#I
60, ate be executed hysician and to burial - transit	Medical	UNPENDED	d AMENDED								
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be. h. After this certificate has been signed by the attending physici: finneral director, page 2 should be detached for use as the burit.	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U		h it at time of	2 F6	etal death ther (Specia		ic pregnancy	23	3d. Date of delive Month	Pry Year
that the de detached i		Part II. Other significant cond			resulting in the	underlying o	cause given in P		_		o the cause of death?
ords, P.O. w requires that as been signed b should be deta	eted by								as an	24b. Were a	obably 4 Unknown
tal Recor	Completed	-						1 ✔ Yes	topsy rformed? s 2 h	death?	
Vital Rec bysician: The l this certificate l	o Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	11	atient 2	ER/Outpatien		Othor	(Check only one) Nursing Home 5	Reside	lence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaid.		27. Manner of Death 1 Natural 5 Pe	28a. Date of (Month, Date) Sep 13, 20	Injury av Year) 312	28b. Time of 0000 hrs	Injury 28	Bc. Injury at World	 Subject st 		jury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Co	uld not be		nily Home	et, factory,	office building, e	or Town	State)	and Number or F Pasadena, MD	Rural Route Number, City
the Hos hin 24 h the Fun	Medical (Physician: To the best of caminer: On the basis of c	examination a							
To with con	Mec	29b. Signature and title of certification	and manner stat	ięd.			License number	r		. Date signed (M	
●,		Mark	Hem)	- F - 1 - 1 - 1 - 1	- 22-)		O.C.M.E.		Se	ptember 14,	2012
3/1		30. Name and address of person Laron Locke MD.	on who completed cause Assistant Medical E			altimore	Street, Baltin	more, MD 21223			
Si	ate	31. Date-filed (Month, 2012)	r) 32. Regis	strar's Signat	ike						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh 931 9-21-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day CATHERINE Month LAWSON 15:57 M 15 Medical 09 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 243-92-1952 60 Director 1 □ M 2 🗱 F 07-05-1952 North Carolina er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 □ No Prince Georges Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3805 Buchanan 20783 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or i inry or other traumatic event, the <u>Medical Exami</u>n 1 Never Married 2 Married Black, White, etc \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Specify:Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Specialist Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Bettie Lawson Lawson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6729 Cathedral Ave, Lanham, MD Orlando D. Lawson Son permit, Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Femetely in Country of Cempace) 1 🔀 Burial 🛨 nation 3 🗌 Removal from State Brentwood Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 9/22/2012 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Bianchi 814 Upshur St. NW, Wash, DC 20011 M01257 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a. Section Struck
ue to (or as a consequence of): Medical Examiner Multi Drug Resistant Urinary Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hypertentian performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 09/15/2012 D70395 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd, Silver Spring, MD 20910-1484 Farrah Abdulsalam 31. Date filed (Month, Day, Year, 32. Regis rar's Signature 2012 SEP 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:02 P M SEPTEMBER 2012 MARY LOPEZ LEWIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 5. Social Security Number **Funeral** Months Director 579-56-6752 1 M 2 X F DEC. 14 1939 NORTH CAROLINA Yrs 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Director Examiner must be notified 1 X Yes 2 No MD PRINCE GEORGE'S LANDOVER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral 2205 VIRGINIA AVENUE 20785 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black White etc 0 ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2X No Specify. BLACK "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12th HOMEMAKER PRIVATE marked other or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ MANUEL LOPEZ AMY WHITAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) S PATRICIA BRADFORD/DGT. 10416 CLEARY LANE BOWIE, MARYLAND 27 Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of cemetery, crematory or other place) Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 9/22/2012 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signafure of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 prne 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TYPE I DIABETES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ATRIAL FIBRILLATION Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical CORONOART ARTERY DISEASE Box 68760 as the ding 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy atten in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death per the g Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, CEREBRALVASCULAR ACCIDENT Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PERIPHERAL ARTERY DISEASE page 2 autopsy has performed death? 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital 1 Tyes 2 XNo 욘 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred nours after death.

neral Director: After the funeral of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral properties of the funeral p Certificate: 28c. Injury at (Month, Day, Year) injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20/12 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

State Registrar Norwan G. Melon

31, Date filed (Month, Day, Year

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32. Registrar's Signature

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SEPTEMBER 19, 2012 4:10 p.m. RAYMOND LOHR

			For		State of N	Marylan				and Mental Hy	ygiene			
			1 - State Registrar Certificate of Death Reg. No. 20						12	3.0	174			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						Date of Death Month Day			Year	3. Time of [
and a	Medic	al	RAYMOND LOH		met and number	1				SEPTE	,-		4:10P	M
	Examin						4c. County							
	Funeral		STELLA MAR 5. Social Security Number	6. Sex		Age (In yrs. Ia	ast birthday)	If Under 1 Year	TIMON If Under 2	4 Hrs. 8. Date of Bi	irth		ALTO ace (State or	Foreign
	Director		213-28-5478	1 X	M 2 □ F	81	Yrs.	Months Days	Hours	Min. (Month, D		Countr		
	show d at		Usual Residence of Deced				Tourselle			MARCH	14,1931		RYLAND	
	ıryland t-f sho ied at	cto	MD	BALT(1	10c. City, Town or Location NOTTINGHAM]			ld. Inside City		
	with the Maryland ; 23a or 28a-f sho ust be notified at	Direct	10e. Street and Number	DAIJI	TO.			10f. Zip Code			10g. Citizen of W	1		ZA NO
	death with the items 23a or ner must be r	Funeral Director	2 CLIPSTONE							ŭ		ryr		
		<u> </u>	11. Marital Status		Was Decedent Ever in U.S.			21236 Was Decedent of Hispanic Origin? (Specify		in? (Specify Yes or No	fy Yes or No- 14. Race -		American Indian,	
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000	2 hours aft "natural", dical Exa	ted	3 Widowed 4 Div		If Yes, Give Year or Dates.		'	Yes 2 XN	о Ѕресіту:		Specify:	WE	IITE	
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'lan	ould be file nd Mental I marked o imatic eve	욘	RAYMOND F. LOHR						ELSIE M. BAUBLITZ					
Maryland	ar is		19a. Informant's Name/Rela	elationship (Type, Print)							ural Route Number, City or Town, State, Zip Code)			
	and 2 ; Health em 27		DIANA K. LO	OHR	SP	OUSE	2 C	LIPSTONE	COURT	NOTTINGE	IAM, MD.	21236	<u> </u>	
Baltimore,	ge 1 a t of H If ite or oth		20a. Method of Disposition 1 🔲 Burial 2 🙀 Crem	ation 3 🗆 Re	emoval from Stat			sition (Name of natory or other pla	ice)	Date	20c. Location - (City or Tow	n, State	
ţ	t. Pag rtmen rtant: njury		4 Donation 5 Of	her (Specify)		A.					GLEN BUR			
Bal	permit. Page 1 and : Department of Healt Important: If item 2 any injury or other	ļ	21. Signature of Funeral Ser	vice Licensee			22	9705 BE		SCHIMUNER OAD NOT	TINGHAM,		_	•]
			23a. Part 1. Enter the disea shock, or heart failure.	se, or complic	ations that cause	ed the death	. Do not ente						Approximate	
	Physician/		Immediate Cause (Final disease or condition	List only one	DEMENTI							Interval Between Onset and Death		
	Medical		resulting in death) a. Due to (or as a consequence of):											
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3760	ficate g phy as the		IS SELVAN E	- 4.										
x 687	endin r use	an/	IF FEMALE: 23b. Was decedent pregnan	23	c. If yes, outcom	e of pregnar	ncy Ideath 3	Ectopic pregnan	ICV		23d. Date	of deliver	у	
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of	ng Ph ter th meral		27. Manner of Death		28a. Date of in	jury	28b. Time of injury	28c. Injur	ry at		how injury occurred		HODIT	<u>on</u>
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	cal	29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated											
	e Hos e Fun e Fun eletely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Tothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ner stated.		
	To the within 7 To the comple		29b. Signature and title of ce		_			29c. Licens			29d. Date signed			
			· CAN	Mes	ent	MP,	CRAI	PR	130	2	9/10	7/2	2015	2
	2/1		30. Name and address of pe	rson who com	pleted cause of	death (Item	23a) (Type, P	rint)				1		
(11 11		TRACIE L. M	ORGAN,	CRNP	2300 T	HII ANE	VALLEY	RD '	TIMONIUM,	MD 21093	2		
	Stat		31. Date filed (Month, Day, Yo		1.				ICD •		<u> </u>			

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			State of Maryland	I / Department of He Certificate of D		tal Hygier	10					
			1. Decedent's Name (First, Middle, Last)		Reg. No.							
9	Physicia				September 18, 2012 2:20 P ^M							
1		/Medical Examiner Joan Mary Linthicum 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of					4c. County of Death	2.20 1				
المها	Examini	ei	Sacred Heart Home	Hyatt	sville]	Prince Geo	rge's				
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	Months Days	Hours Min. (ate of Birth Month, Day, Yea	ar) Coun					
-	Director		200-40-1013	Yrs.	Oc	tober 4,	1946 Mich	igan				
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location			10	0d. Inside City Limits				
	172 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral Director	Maryland Prince George's Hyattsville									
			10e. Street and Number	10f. Zip Code		10g. (Citizen of What Coun	try?				
		la l	5805 Queens Chapel Road	207			ited State					
		nue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of His If Yes, specify Cubar 	panic Origin? (Specify n, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - America Black, White, of					
36			1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	Specify:		Specify: Wh	ite					
9		ed	15. Decedent's Education	16a. Decedent's Usual Occupa	tion	16b.	Kind of Business/Inc	lustry				
215	hin 72 e. an "na Medi	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	unng most of working	Α.						
21	filed within Hygiene. Ither than "	S	Elementary/Secondary (0-12) College (1-4or 5+)	Bank Teller			Banking					
pu	be fill tal H sd oth even	Be	17. Father's Name (First, Middle, Last) Kenneth E. Balge		18. Mother's Name (Fir. Ruthmary		,					
Maryland 21215-0036	2 should be fi and Mental H is marked of aumatic ever	T ₀	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street a				Code)				
Ma	s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical		Jean B. Doyle / Sister	661 Ad Hoc Roa								
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Pla	ace of Disposition (Name of emetery, crematory or other place	Date	200	. Location - City or To					
9	Pages nent of nt: If i		1 N Burial 2 ICremation 3 Hemoval from State	of Heaven Cemeter			ver Spring,	Maryland				
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee MO130	Robert A. Pum 300 West Mont	phrey Funeral	Home/Roc	kville, Inc.	20850-2805				
	-		23a Part / Enter the disease, or complications that caused the death.	JOO WEST HOLIC			ie, ratytaki	Approximate Interval Between				
	Physician	Ŋ.	shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
7	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):									
	Examiner •		Sequentially list conditions.									
4	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Examiner	Bequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that iniliated events c.									
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9	tificate g phy as the	ledic										
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnar 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal				23d. Date of deliver	ery Day Year				
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_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2		29a. Certifier (Check only (Check only and due to the cause(s) and manner as stated. Check only and due to the cause(s) and manner as stated.									
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number						29d.	Date signed (Month,	ned (Month, Day, Year)				
	, 10 Vill		Chronddy	714	3121		9/19/12	_				
	HV		30. Name and address of person who ompleted cause of death (Item	23a) (Type, Print)	, ,		# d += #					
_	`		NURUL CHOWDHURY, MD;	605 Main 5	reet, La	urel,	17207	04				
ŗ	Sta Regist	ate rar	30. Name and address of person who ompleted cause of death (Item NURUL CHOWD (HURY M) 31. Date filed (Month, Day, Year) SEP 2 1 2012	1. Sall								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Douglas Magruder September 12 2012 12:14PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 215 34 5113 Country) Director 1 XM 2 □ F 76 Jan 3, 1936 MD Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederici 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 canturbury ct. 7140 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Nes, Give Black, White, etc 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African Am l Hygiene, other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US GOV+ Aero Biologist 4 415 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bernice permit, Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic Magruder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughkr 315 Broadway SH Tracle Bonev Frederick 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Sept 18 2012 Frederick MD Resthaven 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 110 W. South St dleus Gary L. Roilins Funeral Home Frederick MD 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Therosclerone Cardowascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. ite. Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Medical Certificate: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 170635152 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Frederick MO mo 180 Thes Johnsin Krantz 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 19 2012 Physician/ Marshall Рм Joseph J. September 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 514 Marley Station Road Glen Burnie Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours 270-30-7400 **Director** 77 1**X**□M 2 □ F April 3,1935 Ohio Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 514 Marley Station Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. "natural", 1957 Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owens Illinois Engineer ye 1 and 2 should be filed wit the of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Martha Jane Koehler Joseph James Marshall, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Marshall / Wife 514 Marley Station Road, Glen Burnie, MD 21060 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Page 1 1 Burial 2X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory Inc. 109/20/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ metastate disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes detached the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 1 Tyes 2 X No 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 XX Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death.

neral Director: Af

filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1744804 20/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karin Dodge, 8028 Ritchie Hwy. Suite 134, Pasadena, MD 21122

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

SEP 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#10b, f, perFH, C931, 9/25/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Voor Jacob L. Meier estenber 19,2012 21:37 M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) May 28, 1925 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 218-18-3579 Director 1 XM 2 □ F Baltimore, MD Usual Residence of Dec ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 X Tes 2x No Harford W. Ring Factory Rd. Unit 1310 of Zip Code 21014 10g. Citizen of What Country? Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 Jacob Meier, Sr. Lula A. Rush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1288 Jamison Court Belcamp, Maryland 21017 Craig Meier- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State September Parkville, Maryland 4 Donation 5 Other (Specify) 24, 2012 21. Signature of Funeral Service Licersee Evans Funeral Chaptel & Cremation Services 8800 Harford Road Parkville, MD 21234 23a. P. ft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician/ Stage disease or condition SQUAMOUS CUI LUNG Cance Medical resulting in death) Due to (or as a onsequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown To the Hospital or Attending Physician: The law requires that the c within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ပ 1 Yes 2 Pho 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gartifying Nurse Practitionian To the Sect of my knowledge, doesn't occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0053568 hesdocates 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (PSON) 21019 Day, Year) gistrar's Signature 32. State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 5.15A Meligaris nna Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE **ESSEX** RIVERVIEW NURSING & REHAB. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Months Hours Min (Month, Day, Year) Director 1 M 2 X 218-44-4501 75 12-11-1936 **CYPRUS** Usual Residence of Decedent ms 23a or 28a-f show must be notified at Oa State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD. BALTIMORE PERRY HALL 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5102 ROBINS PERCH LANE 21128 USA items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian "natural", or iter Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: WHITE Specify 3 Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene.
I other than "
vent, the Mer life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **ELEMENTARY** RESTAURANT SELF-EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other. THEODOULOU DEMOSTHENIS SOFOCLEOUS MEROPI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 5102 ROBINS PERCH LANE PERRY HALL, MD. 21128 ALEXIA FARANTOS altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 9-22-2012 BALTIMORE, MD. 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 22. Name and Address of Facility CHARLES S. ZEILER & SON. INC. 21. Signature of Funeral Service Licenses BALTO, MD, 21224 6224 EASTERN AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final As terioscleratic Cornay Vouls Duas Physician/ Hypertensine disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a nonsequence of): cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): ending physician ause as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be very hours after death.

Funeral Director: After this certificate has been signed by the attending physicial. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available 24a. Was an Deneuta autopsy performed? prior to completion of cause of death?

1 Yes 2 No director, page 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗗 🧲 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) water Vircusel 201 01966 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

alevans OD

7310

32. Registrar's Signature

Rtchie H. Chocay

\$ 208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 20,2012 RICHARD MORRIS SR. 8:53A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6518 ROSEMONT AVENUE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) TACOMA Funeral 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Director 391-26-4208 1 **X** M 2 □ F 81 DECEMBER 17.1930 WASHINGTON Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Wedgel Evaniner must be notified at 10d. Inside City Limits Director MD. N/A BALTIMORE 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6518 ROSEMONT AVENUE 21206 **USA** 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Mamied 2 Married à Maryland 21215-0036 1 ☐ Yes 2 K No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates. 1954-1956 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) POSTAL EMPLOYEE FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file ည **NELSON MORRIS** VIOLA REIL should be and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any Injury or other trau MARGARET MORRIS SPOUSE 6518 ROSEMONT AVENUE BALTO. MD. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST VA OWINGS MILLS, MD. 9-28-2012 21. Signature of Funeral Service Lice 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final es Onset and Death Physician/ pha disease or condition resulting in death) Medical Due to (or as a consequence 1) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysiclan Physician/Medical Box 68760 the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No the a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 emente been signature 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? pertension 1 Yes 2 No 25. Was erred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA s after death.

I Director: After this od in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

P.O. Records, **Division of Vital**

hin 24 hours af the Funeral Di npletely filled in

within 2 To the

Medical

To with	29b. Significature and title of certifier	walis	1028177	29d. Date signed (Month, Day, Year)
5.+11	30. Name and address of berson who comple	ted cause of death (Item 23a) (Type, Print) ROLLMD 9110 Ph	HILAISEL PHIA	RD ROSEDALE, M.
Stat	31. Date filed (Month, Day, Year)	32. Registrar's Signature		21357

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

4 Homicide

only one) 29b. Signature and title of certifie

29a, Certifier

determined

SEP 2 1 2012

Serva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ee A. Mandell	State of Maryland / Departs.	rtment of Health and Me rificate of Death	ntal Hygiene Reg. No. 2	012 3018			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Yea	3. Time of Death			
Medical Examiner		I de Cit. T	September 11, 2012	2130 nrs			
	Facility Name (if not institution, give street and number) Saint Agnes Hospital	4b. City, Town, or Location Baltomore	n of Death 4c. County	or Death			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday) If Under 1 Year If Un	der 24Hrs. 8. Date of Birth (MM/DD/YYYY				
Director	216-88-8588 1XXM 2□F	36 Yrs. Months Days Hou	July 10,1976	Foreign CountryMaryland			
Å	Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Fown or Location		10d. Inside City Limits			
low any				1 Yes 2 No			
the Maryland n or 28a-f show tiffed at once. Director	Maryland Baltimore Arbut 10e. Street and Number	10f. Zip Code	10g. Citizen of Wi	1111			
death with the Maryland or items 23a or 28a-f sho must be notified at once-uneral Director	1239 Locust Ave.	21227	United St	tates			
or items 23 inust be mo	11. Marital Status 12. Was Decedent Ever in U.S 17. Never Married 2 Married Armed Forces?	i. 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica		e - American Indian, Black, e, etc.			
er deat , or ite r must	1XX Never Married 2 Married Armed Forces? 1 Yes 2 XXNo 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specif		White			
urs aft tural" d by	or Dates:	16a. Decedent's Usual Occupation (Giv		usiness/Industry			
6 72 bo	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life, DO NO					
5-0036 led within 72 hours after the within 72 hours after the "natural", the Medical Examiner Completed by	9grade N/A 17. Father's Name (First, Middle, Last)	Unemployed Table	Unemp1.c	-			
21215-(uld be filed v Mental Hygi marked oth c event, the	Dennis Mandell		ers Name (First, Middle, Malden Surname sy May Phillips)			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. a 77 is marked other than "natural", or items 23a or 28a-f abo rumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and No	umber or Rural Route Number, City or Tow	n, State, Zip Code)			
두 말씀 되루	Mark Mandell / Brother 20a. Method of Disposition 20b. Pi	7361 Ridgewater (Ct.Apt.#102.Glen Bur	rnie MD. 21060			
Baltimore, permit. Pages I as Department of He Important: If the injury or other tr		ace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location -	- City or Town, State			
timent present:	4 Donation 5 Other Specify: Mount Zion Cemetery Sept 22,2012 Lansdowne, Maryland 21 main of Funeral Service Licensee.						
Derm Depa Inpe	21 Onally of Funeral Service Licensee 22. Name and Address of Facility ROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, MD. 21227						
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/Medical. Examiner	Immediate Cause (Final disease a. Combined effec	ts of Methadone an	d Alcohol	Death			
-21	or condition resulting in death) Due to (or as a consequence of):						
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	:					
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Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been sigled in by the funeral director, page 2 should be ertification: To Be Completed	WAR THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF T		performed?	death? ✓ Yes 2 No			
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ion of \\ tending Phy eath. tor: After th the funeral of attion; To	1 Natural 5 Pending (Month, Day, Year)	1 Yes 25					
/isic or Atte her des hirecto n by th	2 X Accident 3 Suicide 6 Could not be 28e. Place of Injury - At hor	fd 9:16 pm re, farm, street, factory, office building,	etc. 28f. Location (Street and Number	er or Rural Route Number, City			
Division o spital or Attending tours after death. The filled in by the function: Certification:	4 Homicide determined (Specify) Reside	nce	or Town, State) 1239 Baltimore, MD.	Locust Ave.			
5 - 3 > 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and						
To the Bouthin 24 To the For the For the For completel	29b. Signature and title of certifier	29c. License numbe		ed (Month, Day, Year)			
	() $()$ $()$ $()$ $()$ $()$ $()$ $()$	O.C.M.E.	September				
	30. Name and address of person who completed cause of death (Item 23a)						
	Donna M. Vincenti, MD Assistant Medical Exam		t, Baltimore, MD 21223				
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	h ball					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MILLER 9:59 A M SEPTEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ILESVILLE MILFURD MANUR BALTIMURE 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 1 □ M 2 🗓 F 213-16-9036 81 08/10/1931 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6640 DALTON DRIVE 21207 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. <u>م</u> 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e JOSEPH SIBBLE BEATRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 LAURELWOOD COURT, BALTIMORE, MD 21209 JANET MILLER/DAUGHTER Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
MOSES MONTEFIORE
WOODMOOR HEBREW 🐰 Burial 2 🗆 Cremation 3 🗀 Removal from State 09/13/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature Funeral Serv 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Pregnant at time of death Unknown the 1 Yes 2 Unknown P.O. I by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GANGRENOUS 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the ! only one 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) M-0. D57722

DHMH 17 Rev 06-2011

State Registrar 1838 GREENE TREE RUAD #300 PKESVILLE MO 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P.

/32. Registrar's Signature

LEUNAR RICHARDSUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eter Marvit	1- For State	ate of Maryland		ent of Health ete of Death	and Mental I		g. No. 201	2 3018
Physician/	1. Decedent's Name (First, Middle	e,Last)				2. Date of Death	1	3. Time of Death
Medical Examiner	1 11 111			VIT		Month September		2307 hrs
	4a. Facility Name (if not institution Johns Hopkins Hospita			4b. City, Tov Baltimo	wn, or Location of Dea ore	ith	4c. County of Dea	
Funeral			e (In yrs. last birth				n(MM/DD/YYYY) 9, B	irthplace (State or
Director	003-54-8056	1 M 2 F	51	Yrs. Months	Days Hours M	10/04/		ountry) MA
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	MD N	/A	BALT	IMORE				1 X Yes 2 No
the Maryland a or 28a-f sh tified at one Director	10e. Street and Number			10f. Zip C		10	g. Citizen of What Co	untry?
	2843 CHESTERF	IELD AVENUE	Ever in U.S.		21213 of Hispanic Origin? (Specify Yes or No-	USA 14. Race - Ame	erican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Ma	Armed Forces			Cuban, Mexican, Puer		White, etc.	,,
s after d		orced If Yes, Give Yeer or Dates:			No specify:		opeony.	WHITE
hours Fram	15. Decedent's Education (Spec Elementary/Secondary (0-12)	cify only highest grade con College (1-4 or	d		ccupation (Give kind on ng life. DO NOT use r		16b. Kind of Business	i/Industry INSTITUTES
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그 목 등 등 등	NARIKO MARVIT-		F				BALTIMORE	
trans	20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of	Disposition (Name bry or other place)	of cemetery,	Date	20c. Location - City of	or Town, State
Baltimore, cernit. Pages 1 a Department of He Important: If ite	4 Donation 5 Other Sp	pecify:	HILLTO		E CORP. 09			
Baltimore permit. Pages I Department of H Important: If injury or other	21. Signature of Funeral Servi	Licens					SON & BROS	
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Medical Examiner	failure. List only one cause Immediate Cause (Final disease	Maritimle Originals	ot Wounds					Death
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Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):					
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O, e be ex ysician burial	UNPENDED	AMENDED					23d Date of delive	any
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Records, In The law requires ficate has been significate to a should be Completed						24a. Was a autops perfori	sy prior to	autopsy findings available completion of cause of
tal Rectan: The Lectificate hector, page				26	. Place of Death (Ched	1 ✓ Yes 2		
Vital ysician: ysician: his certi director	25. Was case referred to medica examiner? 1 Yes 2 No		ent 2 🗸 ER/Ou		Other C		Residence 6 Oth	er:
ing Physical ding 27. Manner of Death	28a. Date of Injune (Month, Day, Sep 17, 2012	ury 28b. 7		c. Injury at Work?	28d Describe h Subject shot	now injury occurred		
sion ttendi death. ctor: /	1 Natural 5 Pend 2 Accident Inve	stigation			1 Yes 2 ✔ No			Pural Parta Number City
Division or spital or Attending rours after death. neral Director: After filled in by the function. Certification:	deta	d not be	njury - At home, fa ngle Family H	rm, street, factory, o	office building, etc.	or Town, St		Rural Route Number, City
Di Hospital 14 hours a Funeral I cely filled	4 Homicide 29a. Certifier 1 Certifying P	hysician: To the best of m	ny knowledge, dea	th occurred at the ti	me, date and place, a	nd due to the cause	e(s) and manner as st	ated.
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Ž Ž	29b. Signature and title of certific	er	, 1		License number O.C.M.E.		29d. Date signed (M September 18,	
	30. Name and address of person	who completed cause of	death (Item 23a)					
0		Assistant Medical E		0 W. Baltimore	Street, Baltimor	e, MD 21223		
State		2. Registra	ar's Signature	back				
Registra	961 8 4 6	VIL ALEMAN	10.19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 17 2012 03:55AM PEARLMAN WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 3111 SHELBURNE ROAD If Under 1 Year If Under Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours **Director** 212-20-8194 1 **X** M 2 □ F 03/10/1925 MD 87 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State must be notified at Director 1 Yes 2X No BALTIMORE BALTIMORE MD 10f. Zip Code 0 10e. Street and Number 10a. Citizen of What Country? Funeral items 23a 3111 SHELBURNE ROAD 21208 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. ıral", or iten Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced "natural" Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) I Mental Hygiene. narked other than "life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ PHARMACIST PHARMACY of Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RUBENSTEIN PEARLMAN ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA PEARLMAN/WIFE 3111 SHELBURNE ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State BNAI ISRAEL CEMETERY: 09/20/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signa (re of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Oyear disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury Exami use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death signed by the ail 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to edical examiner? funeral director. 26. Place of Death (Check only one) 2 1 🗆 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending iniury Natural s after death. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours af

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day Year) 29b. Signature and fifte 29c. License number DSI

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Spe, Print Charles St Baltmd 21204

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-	Medic Examin		4a. Facility Name (if not institution, give s	treet and number)			-	Location of Death		4c. Count		
· march			Carroll Hospita 5. Social Security Number 6. Sec		e (In yrs. last birt		estmi	nster If Under 24 Hrs.	8. Date of Birt		arro	hplace (State or Foreign
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pu	e filed w ntal Hygi ed other event, 1	To Be	17. Father's Name (First, Middle, Last) Edward Carroll	Danawan				18. Mother's Nan	ne <i>(First, Middle,</i> xine Goo		ne)	
Maryland 21215-0036	2 should be f th and Menta ?7 is marked treumatic ev		19a. Informant's Name/Relationship (Ty)		Son) 191	h Mailing Addr	ess (Street :	and Number or Rui			State. Zic	Code)
			Mr. William Russe									
Baltimore,	ge 1 and t of Heal if item?		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	camete	of Disposition (A	or other place	ce)	Date (0.01.0	20c. Location	-	1
ţ	t. Pag tmen rtant:	4 Donation 5 Other (Specify) Lake View Mem. Park 9/21/2012 SykeSVIIIe, FID										
Bal	permi Depar Impo eny ir		21. Signature of Funeral Service License	indt N	00764	PC PC) Box	195 Syke	sville,	MD 2178	лме о 34	CHAPEL, PA
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between									
-	nysician/	ř	Immediate Cause (Final disease or condition Onset and Death Onset and Death									
-	Medical Examiner		resulting in death)	Due to (or as	a consequence	of):		Ceni	12 164	alle)	κ_{l}	
		Jer	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying	b. Due to (or as:	consequence	of):			•		1/2	
	executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c					7		7	
		I —	resulting in death) Last	Due to (or as	a consequence	of):			~	60%		
760	cate be exe	edic		d								
89	ath certifice attending p for use as	Σ	ZSD. Was decedent pregnant	23c. If yes, outcome	of pregnancy	th 3∏ Ector	sic pregnan	cv		23d. D	ate of de	livery
Box 68760	the death by the atte tached for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a						N	lonth	Day Year
P.O.	Attending Physicien: The law requires that the death certificate be st death. sctor: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	y Ph	Part II. Other significant conditions co	ontributing to death b	out not resulting	in the underlyi	ng cause gi	iven in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
Js, F	requires the been signal should be	ed by		4.22					10	Yes 2 No	3 🗆 P	robably 4 🗌 Unknown
Records,	law req has bee ge 2 sho	Completed							24a. Was	posy	. Were au prior to death?	topsy findings available completion of cause of
Re	i clen: The la certificate ha rector, page								1 ☐ Yes	ormed? 2 D No	1 Yes	s 2 🗆 No
<u>ita</u>	sicien: The certificate irector, pag	Be	25. Was case referred to medical examiner? Yes 2 No	Hospital:	0 T 5D/0)	Oth	lace of Death (Che		idonos 6 🗆 O	hor (Cnor	26.4
of <	g Phys er this eral di	<u>ا</u>	27. Manner of Death	28a. Date of inju _(Month, Da	ıry 28b.	Outpatient 3 Time of injury	28c. Injur	ry at	lome 5 Res 28d. Describe	how injury occu		-Standing
8	ending leath.	ficat	1 ☐ Matural 5 ☐ Pending 2 M Accident Investigation 3 ☐ Suicide 6 ☐ Could not b	9-14-1	2 un	known ^M		Yes 2 No	subject	t fell	UIII	Position
Division of Vital	ospital or Attendi hours after death ineral Director. A ly filled in by the f	Sert	4 Homicide determined	28e. Place of Inj building, et		farm, street, fac	tory, office	Lome		(Street and Num wn, State)	ber or Ru	aral Route Number, 3/784
Ω	To the Hospital or Attending Phy within 24 hours, ther death, To the Funeral Director, After thi completely filled in by the funeral	Medical Certificate:	29a. Certifier (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (Check (tated.			
	the H thin 24 the Fi	Ž	(Check 2 Medical Examination only one) 3 Certifying Nurse 29b. Signature and title of certifier	se Practitioner: To the	ne best of my kn	owledge, death	occurred at 29c. Licens	the time, date and p	place, and due to	the cause(s) and 29d. Date sign	l manner a	as stated.
	o 2 ≰ o	1	Don organization and the or our direction	1				7193	6	9-1	8-/	ス
	132		30. Name and address of person who d	comp eted cause of o	death (Item 23a)	(Type, Print)		Ave, Wes		40 n	77	21167
			31. Date filed (Month, Day, Year)	Registr	ar's Signature	OFFICINO	N 19/ 1	1766, WPS	7 111113	14, 11	19,	1117/
	Sta Registi		SEP 2 1 201	2 Denous	1.	backer	7					

12-06878 Mai

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rckel Ross	State of Maryland / Department of Certificate of Registrar		lygiene Reg. No. 20	12 30186		
Physician edical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year September 11, 2012	3. Time of Death 0654 hrs		
	4a. Facility Name (if not institution, give street and number) Central Avenue @ Rollins Avenue	4b. City, Town, or Location of Death Capitol Heights				
Funeral Director	5. Social Security Number 578-25-6946 Usual Residence of Decedent 6. Sex 1 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	s. 8. Date of Birth(MM/DD/YYYY)			
eath with the Maryland items 23a or 28a-f show any ust be notified at once. nneral Director	10a. State ND 10b. County Prince Georges Capital 10e. Street and Number 409 Abel Ave	Heights 10f.Zip Code 20743	10g. Citizen of Wha	10d. Inside City Limits 1 X Yes 2 No at Country?		
nurs after d	3 Widowed 4 Divorced in res, Give rear 1	as Decedent of Hispanic Origin? (S fes, specify Cuban, Mexican, Puerto Yes, specify: Yes 2 X No specify: nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret	White, Specify: work done 16b. Kind of Bus	Black		
21215-0036 ould be filed within 72 hour ould be filed within 72 hour ould a Meeting Hygiene. I marked other than "natu ic event, the Medical Exar To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 17. Father's Name (First, Middle, Last) Norman Thompson	student 18.Mother's Name	e (First, Middle, Maiden Surname) beth Ross			
≥ 2 ÷ 2 =	19a. Informant's Name/Relationship (Type, Print) Elizabeth Ross/mother 19b. Mailir 409	g Address (Street and Number or Abel Ave. Cap				
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum	1 x Burial 2 Cremation 3 Removal from State crematory or o Herit	age Cemete	/20/12 Waldo:	city or Town, State rf, MD.		
M	MO1 388 D 23a. Part I. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility 56.3 unn & Sons-	D(C 20019		
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Death Death Death					
), be executed ician and untal - transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):				
0, e be executed ysician and burial - transit	d. UNPENDED AMENDED					
30x 6876C death certificate to attending phys I for use as the bysician/Me	past 12 months?	etal death 3 Ectopic pregnather (Specify)	23d. Date of d Month	elivery Day Year		
P.C es that igned be deta	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribution 1 Yes 2 ✓ No 3	ute to the cause of death? Probably 4 Unknown		
Records The law requirement is the second page 2 should Complete			autopsy pri- performed? de 1 ✓ Yes 2 No 1	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital hysician: this certiful director, To Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check Other 4 Nursin	only one) ng Home 5 Residence 6	Other: Scene		
tending Physician: eath. or: After this certif the funeral director, ation: To Be (1 Yes 2 No Final Figure 2 Exodupation 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Ves 2 No Found Final Sea Date of Injury FOUND: Sep 11, 2012 0650 hrs		28d. Describe how injury occurred Subject shot			
Division ospital or Attending to ours after death. Beral Director: Aft filled in by the function:	3 Suicide 6 Could not be determined (Specify) Sidewalk		28f. Location (Street and Number or Town, State) Central Avenue @ Rollins Ave			
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occurred a	at the time, date and place, and due	e to the cause(s)		
2	29b. Signature and title of certifier Car of Hall a m	29c. License number O.C.M.E	September 1	1 (Month, Day, Year) 12, 2012		
21	Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD	Baltimore Street, Baltimore,	, MD 21223			
State Registra		/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aren Ridgely			nent of Health and Mental Hi cate of Death		2012 3018
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Karen Ridgely		Date of Death Month September	
		4a. Facility Name (if not institution, give street and number) Harbor Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs			(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		217-84-2305 1□M 2XXF	47 Yrs. Months Days Hours Min.	June 2	3, 1965 CountMaryland
v a0y	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
faryland 28a-f show I at ooce.	횭	Maryland Baltim	nore City	1100	1 Yes 2 No 3. Citizen of What Country?
the Mai	Director	2216 Round Road	21225		nited States
ath with	a	11. Marital Status 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
after de	by Fun	1 Yes 2 XX No 3 Widowed 4 Divorced of Pates:	1 Yes 2 No specify:		Specify: White
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired 		16b. Kind of Business/Industry
0036 vithin 7; ene. er thao	Completed	12yrs N/A Di	sabled		Disabled
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importate: If item 27 is marked other that "catural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at occa-	Be Co	17. Father's Name (First, Middle, Last) Gary Joseph Bowen	18.Mother's Name Frances		
D 21; should b and Men	2	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or F	Rural Route Numb	eı, City or Town, State, Zip Code)
e, MD 1 and 2 sho Health and item 27 is	}	20a. Method of Disposition 20b. Place	713 Aldgate Green, Base of Disposition (Name of cemetery, atory or other place)		Maryland 21227 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Atlar	ntic Crematory Sep	t 21,201	2 Glen Burnie,Maryland
Balt permit. Depart Impor		21 8 gnature of Funeral Service Licensee	22. Name and Address of Facility AMB		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardiac o	r respiratory arres	t, shock, or heart Approximate Interval Betwein Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atheros. Jerof Due to (or as a consequence of):	ic Cardiovascular Disease	 ,	. Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
ecuted and - transit	a Ex	d.			
50, tte be exc hysician e burial -	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnance	v		23d. Date of delivery
Box 6876: death certificat he attending phy of for use as the	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 1 Pregnant at time of death	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	ncy	Month Day Year
Box ne death the atte	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	- Cite () France	Los Billio	acco use contribute to the cause of death?
P.O.	ē	Part II. Other significant conditions contributing to death but not resulti Obesity	ng in the underlying cause given in Part I.		2 V No 3 Probably 4 Unknown
of Vital Records, ag Physiciae: The law require ther this certificate has been si meral director, page 2 should b	Completed			24a. Was an autopsy	prior to completion of cause of
tal Reco	Com		D D 12 12 14 14 14 14 14 14 14 14 14 14 14 14 14	perform	
Vital tysiciso this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/	26.Place of Death (Check of Dutpatient 3 DOA Other Dutpatient 3 Nursin	g Home 5 R	esidence 6 Other:
n of ding Pt. h. After a funeral	in in		Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred
Division tal or Atteodi 13 after death.	Certification:	2 Accident Investigation	farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rural Route Number, City
Ospital ospital uoeral I	S	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge determined (Specify)	and a course of at the time date and place and		
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteding Physiciao: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge, done) 2 medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred a	t the time, date ar	and place, and due to the cause(s)
	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 16, 2012
3 /	-	30. Name and address of person who completed cause of death (Item 23a))		
[V	o to	200 Designation Company	0 W. Baltimore Street, Baltimore, M	/ID 21223	·
Regist		SEP 2 1 2012 June 1.	pare		

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AMEND ITEM#19a.perFH, G923, 10/16/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Sauser Calo - 14 9 2141 17 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Bultimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🖫 F 220-48-5662 Usual Residence of Deced 64 12/20/1947 MD 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Pasadena Anne Arunde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7903 Wiltshire Court 21122 items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Loan Processor Mortgage other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Wojciechowski Frances Russ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 sl of Health a If item 27 is Nicholas J. Sauser Sr./Spouse 7903 Wiltshire Ct., Pasadena, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/21/2012 Crownsville, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 strong that death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart fa disease, or complic Approximate ure. List only one Interval Between Onset and Death e on each line Immediate Cause (Final aurtic Physician aneurysm disease or condition resulting in death) unkingun Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause E for Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last burial Physician/Medical Division of Vital Records, P.O. Box 68760 the phy IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown 9 Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 **M** No 1 X Yes 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပ 1 Marient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No s after death.

I Director: At the function by the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

ADAM SHEELY

31. Date filed (Month, Day, Year) SEP 2 1 2012

Baltimore MD

32. Registrar's Signature

R195325

CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 816 Glen Alben Dr.

9/19/12

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ETEMBER 16 2012 Mae Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death GLEN BURNIE BALTIMORE WASHINGTON MENCAL ANNE HEUNDE ENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Director 212-46-5190 1 M 2 🔀 F May 17 1947 Maryland Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show treumatic event, <u>the Medicel Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Anne Arundel Glen Burnie ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Hamlen Road 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Department of Health and Mont. Important: If item 27 is marked any injury or com-Walter Wosk Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Smith 717 Hamlen Rd. Glen Burnie MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State Metro Crematory Inc.9/19/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) LFuneral Se 22. Name and Address of Facility 21. Signature Stallings Funeral Home PA 3111 Mountain Rd Pasadena MD 23a. Part 1. Enter the hoease, or compli-shock, or heart fail by List only one Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Due to (or as a consequence of): Physician/ KULMONAR disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exal Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ģ Day been signed by the s should be detached 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 8c. Injury at Natural 5 🗌 Pending injury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Glen Burnie 31. Date filed (Month, Day, Year) SEP 2 1 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Month Stanley 4:50 AM 09 2012 Medical 4a. Facility Name (if not institution, give street and number)
University & Maryland Medical Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Year) Hours 1 🔀 M 2 🗆 F Director 217-72-6131 55 13, Virginia 1956 Oct. Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Md. 1 Yes 2 XNo Anne Arundel Pasadena 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 7689 Oak Lane 21122 USA items Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene.

Tent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fire Protection Installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph E. Stanley V. Maxine Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7689 Oak Lane Nancy C. Stanley (Spouse) Pasadena, Md, 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify) cemetery, crematory or other place, 9/15/12 Metro Crematory Baltimore, Md. Funeral 5 Stallings Funeral Home PA <u>3111 Mountain Rd. Pasadena Md.</u> 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sepsis Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner bone marrow suppression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 the t as use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year signed by tall d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by , fusarium infection Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Dancytopenia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page 2 has autopsy performed certificate Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.

Funeral Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F

State Registrar 31. Date filed (Month, Day,

only one 29b. Signature and

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEGUT Naderi 22 S. Greene St. Baltimore MD 21201 32. Registrar's Signature

DHMH 17 Rev 06-2011

P27357

29d. Date signed (Month, Day, Year)

09/14/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2 0 2 0 1 2 Physician/ SEPTEMBER 9:05 A M ROSE MARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL
Social Security Number | 6. Sex | 17. Age fin vrs. last birthday FREDERICK FREDERICK 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. (Month, Day, Year) Months Days Min 220-16-1407 Director 1 M 2 Z F 86 MD. MAY 20,1926 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ould be filed within 72 hours after death with the Maryland ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD FREOBRUK FREDERICK 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral WEST SOUTH ST. 26 21701 US A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK Completed 3 Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) HOOD COLLEGE Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTK TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) murbock ROSE MATTHEWS of Health and Menta fitem 27 is marked r other traumatic e 5AM ULL Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7915 Liberty Rd. DAU LLEN Baltmore lubaya 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State FRIRUIGN 360 28,201 PREDOLLIR Com. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CARY L. ROLLINS FUNGATE SEME ollein muy d. FREOGRICA MO 21701 SOUTH SI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCT Immediate Cause (Final nset and De Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No |유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c. License number 29d. Date signed (Month, Day, Year) D8981773 30) Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRAYECH BOLKWA, 196 TILLVE, PLEDENCK, MD2/702 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 Physician/ 15:53 M Month nthia JOIJ Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 217-04-2462 Min Director MD 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f sho Important: If teem 27 is anarked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MO 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give 3 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) HAIR Elementary/Secondary (0-12) College (1-4 or 5+) SALON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ည Davis MURIEL 200498 19a. Informant' ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CTU-6 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sept 16, 2012 Smithsburg MD 4 ☐ Donation 5 ☐ Other (Specify) PULLIALS PON. HUME 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Alcoholic Hepatitis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f 9 Nunch 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No |₽ 1 🗌 Yes 1 Nation 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No 2 Accident Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature 1356617427 September 14,2012 ss of person who completed cause of death (Item 23a) (Type, Print)
Magicleson, MD, UMMC, 225, Greene Street, Bultimore, MD 21201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Elisabetta P. Savino 2:00a M Sept Medical 20 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2922 Northwind Road Baltimore Carney Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours Min 214-44-6462 **Director** 98 1 □ M 2 🔀 F 6-27-1914 Italy Usual Residence of Decedent show 10a. State 돥 10c. City, Town or Location Director 10d. Inside City Limits notified MD Baltimore 28a-f Carney 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 2922 Northwind Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) In own home 2nd Homemaker alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Liberato Cerrone Rosaria Luordo 19a. Informant's Name/Relationship (Type, Print) son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Diamante Savino 3113 Northwind Rd., Carney, Maryland 21234 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State ò Department of Important: If any Injury or once. 9/24/2012|Baltimore, Maryland Oaklawn 4 ☐ Donation 5 🛣 Other (Specify) entomb. 22. Name and Address of Facility Joseph N. Zannino Jr. 263 S. Conkling St., Baltimore, MD 21224 23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Oncet and Death Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit and that initiated events physician are purial-t resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year signed by the a 1 Yes 2 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No death? certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17perFH. G931,9/21/2012 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death Physician/ Bernard Smith, The Month 09 930AM IB 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8602 POLL Hill Windsor Mill Baltimore Court 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 215.46.7678 Director 1 M 2 🗆 F 1948 04 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Windsor Mill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8602 Funeral 21244 Hill Court USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Finance 12tharade 5 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ္ B. Smith Vernon Geneva Mingo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) Elizabeth Smith 8602 Polly Hill Court Windson Mill, MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 09/2012012 Baltimore, MD 22. Name and Address of Facility Vaughn C. Green & Funeral Services 21. Signature of Funeral Service Licensee Vaugo Randallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Pnysician 1900 HULHUIB disease or condition Medical resulting in death) Due to (or as a sequence of): Examiner GENTLE: PARBAH Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of sician and buriai-transit Exami HNJERGER 210H or Attending Physician: The law requires that the death certificate be executed Due to or as a consequence of): physician s the burial Box 68760 < Physician/Medical use as 1 attending i IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day signed by the at 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: Tha law require within 24 hours after death.

To the Funerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should FALLIRA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 99312 1984EB performed 1 ☐ Yes 2 ☐ No 1 Yes 2 10 **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N residence 6 Other (Specify) 1 ☐ Yes 2 🗖 🗖 မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 18/12 MODO SEIS base of death (Item 23a) (Type, Print) DEDWAR CINCER 4073. 31. Date filed (Month, Day, Year) State 2.1 Registrar

		Plea	se Type or Pri	nt in Blac	k Indeli 9a, PERI Jepartme	ble Ink	Ensure	All Copie	s Are	Legible	
	ľ	For State Registrar			Certifica				Reg. No	201	2 30195
Physicia Medi		1. Decedent's Name (First, Middle,	11 0	nce	Jr.			2. Date of D Month		y 18 Year 20	3. Time of Death 2 5:30 p M
Examir	ner	4a. Facility Name (if not institution, Good Samarita	n Hospita	e	4b. Cit	_ /.	Location of Dear		4c.	. County of Dea	th
Funeral Director		5. Social Security Number 315-70-6940 Usual Residence of Decedent	7. Age 1 ☑ M 2 ☐ F	e (In yrs. last birth	Month	der 1 Year s Days	If Under 24 Hrs Hours Min		ay, Year)	Co	thplace (State or Foreign untry)
iaryland ?a-f show ified at	Director	10a. State 10b. County	. 1	10c. City, Town	or Location						10d. Inside City Limits
death with the Maryland items 23a or 28a-f sho ner must be notified at		10e. Street and Number	a Court	l soling	10f. 2	Zip Code	1110	7	10g. Cit	izen of What Co	
FPLC, M;///mm ife, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give		If Yes, sp	edent of His ecify Cuban	n, Mexican, Puer	pecify Yes or No to Rican, etc.)		14. Race - Ame Black, Whit	
21215-0036 within 72 hours after giene. er than "natural", or et than "the Medical Exami, the Medical Exami,	Completed	3 ☐ Widowed 4 ☑ Divorced 15. Decedent (Specify only highes)	Year or Dates.		Decedent's Us 'Give kind of w	sual Occupa ork done du		rking		Specify: K	/Industry
d 2121 d 2121 ed within 73 Hygiene. other than ent, the Me	Be Con	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	College (1-4 or 5		ife. DO NOT y	se retired)	Mana		N	Janut	Cacturing
Maryland S should be filed th and Mental Hy 27 is marked oth traumatic event	To	William H	. Spence	Sr.			18. Apther's Na	me (First, Middle	, Maiden S OC/	Surname) Man	
Spenies Management of Health an fitem 27 is rother traus		19a. Informant's Name/Relationship	oence/50	20b. Plac ∉ of	Mailing Addre	ctor	Aun ve	iral Route Number	inoi	Town, State, Zi	21218
ti Page tment c rtant: If		1 M Burial 2 Cremation 3 4 Donation 5 Other (Sp	ecify)	confetery	cremato ry or	Sher plage	9-2	Date 4-2012	20c. Lo		ore MD
Balti permit. Departr Importa any inji		21. Signature of Funeral Service Lic	C. Suer		872	8/jb	of Facility au	Bad Rai	reepe	1/stown	modiliss
Ph∫si⊏ian Medical	g. 1	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line	Lo care	litis	de of dying,	, suc f as cardiac	or respiratory a	rest,		Approximate Interval Between Onserand Death
Examiner	er	Sequentially list conditions,	b. —	consequence of							
executed an and urial-transit	Examine	if any, leading to immediate outco. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	С	consequence of							
760 cate be exphysician			d	· 						:	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours afred death. To the Funeral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3				2	23d. Date of de Month	ivery Day Year
ds, P.O uires that the n signed by uld be deta	è	Part II. Other significant condition	s contributing to death bu	ut not resulting in	the underlying	g cause give	n in Part I.				the cause of death?
Record The law rec ate has bee	Completed				···			24a. Was auto 1 Yes		prior to death?	topsy findings available completion of cause of
ician: certific	Be	25. Was case referred to medical examiner?	Hospital:			26. Plac	ce of Death (Che	ck only one)			
of V g Phys er this	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie		ne of	28c. Injury a	4 ☐ Nursing F	lome 5 Residence 128d. Describe 1			ify)
ttendin death. tor: Aff	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	t he		ury M		es 2 🗆 No				
Divis pital or Ar ours after eral Direc		4 Homicide determine	ed 28e, Place of Injur building, etc.	(Specify)				City or Tov	n, State)		al Route Number,
ne Hos in 24 ho ne Fune pletely	Medical	Uneck 2 L Medical Exa	hysician: To the best of r miner: On the basis of ex urse Practitioner: To the	amination and/or i	nvestigation in	n my opinion	death occurred	at the time date a	and place	and due to the o	ballea(e) and mannar stated
To the within To the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence of the commence	- I	29h Signature and title of certifier			00					signed (Month	, Day, Year)
5		30. Name and address of person when the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	o completed cause of de	ath (Item 23a) (Ty	pe, Print) Reven	Blve	l, Ba	ltimore	,		
Stat Registra		SEP 2 1 2012	32. Registrar	's Signature	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate of	Death	, c	eg. No.	2 3019
Physic Medical Exam					2. Date of Dea Month	th Day Year er 17, 2012	3. Time of Death 0245 hrs
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location of		4c. County of Death	
Agent"		Anne Arundel Medical Center Annapolis Anne Arundel					
Funeral Director		221-64-9632 _{1XM 2} F	yrs. last birthday) 32 Yrs.	If Under 1 Year If Under Months Days Hours		Foreig	hplace (State or n Intry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Location	on			10d. Inside City Limits
*	or	Maryland Anne Arundel		Annapolis			1 Yes 2 X No
ne Maryland or 28a-f show fied at once,	Director	10e. Street and Number		10f, Zip Code	1	0g. Citizen of What Coun	•
ith the 23a or		412 4th Street 11. Marital Status 12. Was Decedent Ever	in II C 42 Wes	21403		United S	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X	No If Ye	B Decedent of Hispanic Originals, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	ean Indian, Black, Nite
ırs afte t ural",	by	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete		Yes $2 X $ No specify: 's Usual Occupation (Give k	ind of work done	Specify: WI 16b. Kind of Business/Ir	
5 72 hou nn "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life. DO NOT u			
5-0036 led within 72 h Hygiene. I other than "n,	dwo	10	Paint	/ Fiberglass		Boat Repa	iir
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) Robert Swager			s Name (First, Middle, M 1yn Baumga:	,	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Tant: If item 27 is marked other than or other traumatic event, the Medical	70	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Numb	per or Rural Route Num	ber, City or Town, State,	
alth		Robert Swager / Father 20a. Method of Disposition		lawthorne Str	eet, Shady Date	Side, MD 20	
Baltimore, permit. Pages I a Department of He important: If ite		1 Burial 2 X Cremation 3 Removal from State	crematory or other	er place)			
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Thomas Green	Metro Crem	atory Inc.	09/20/2012 remation	Baltimore,	Maryland
Dep Denti	1 3	Thomas Lun	299	Frederick Ro	oad, Baltin	nore, Maryla	and 21228
Physician Magical		23a. Part I. Enter the disease, or complication; that caused the difailure. List only one cause on each line	eath. Do not enter the	e mode of dying, such as car	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	ľ	Immediate Cause (Final disease or condition resulting in death) a. Heroin and A Due to (or as a consequent		toxication ar	nd Cocaine	Use	Death
		Sequentially list conditions, b				100	
	nine	if any, leading to immediate Due to (or as a consequen cause. Enter Underlying Cause	ce of);				
Isi ed A	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequen	ce of):				
3760, ficate be executed g physician and sthe burial - transit		x UNPENDED AMENDED 23a, 27	.28a-f.pe	r me,g931 9-2	28-12 sm		
760, icate be physicate burn	/Medical	IF FEMALE: 23c. If yes, outcome of p		76		23d. Date of delivery	
Box 68; death certifi he attending d for use as t		23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of	of dooth =	Il death 3 Ectopic p er (Specify)	oregnancy	Month Da	y Year
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending	Physiciar	1 Yes 2 No 9 Unknown g Unknown					
, P.O. res that the signed by be detach	by P	Part II. Other significant conditions contributing to death but r	not resulting in the und	derlying cause given in Part		pacco use contribute to the	
ds, equires een sig							psy findings available
Records, The law require ficate has been si	Completed				autops perfori	prior to co ned? death?	mpletion of cause of
tal Re		25. Was case referred to medical		26.Place of Death (C	1 ✓ Yes 2	No 1 ✓ Yes	2 No
of Vital ng Physician: ther this certi	To Be	1 100 2 110	ER/Outpatient	3 DOA Other	Nursing Home 5 7	Residence 6 Other:	
n of ding P h. After	<u></u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year)	28b. Time of Inju	. 1 – –		ow injury occurred	
Division tal or Attendi rs after death.	icati	2 Accident Investigation 28e Place of Injury -		factory, office building, etc.		treet and Number or Rura	Poute Number City
Divisior Hospital or Attent 24 hours after death Funeral Director: etely filled in by the	Certification:		cnown	,,	or Town, St	ate) unknown	r route reamber, only
4 4 0	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination					
To the within To the compl	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	
		and		O.C.M.E.		September 17, 20	12
		30. Name and address of person who completed cause of death (I Ana Rubio M.D., Ph. D. Assistant Medical E.		V. Baltimore Street, E	Baltimore, MD 212	223	
St Regist		31. Date filed (Month, Day, Year) 32. Registrats Sign	nature				
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ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 7000 Saman Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. Hours Director 1 XM 2 F 216-20-3911 85 9-12-1927 MARYLAND within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Wedical Evaniner must be notified at 10d. Inside City Limits Director MD. GLEN ARM BALTO. 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5840 GLEN ARM ROAD 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) BUSINESS OWNER **INSURANCE AGENCY** 12TH Be t. Page 1 and 2 should be filed tment of Health and Mental Hy rtant: If Item 27 Is marked ot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILFRED H. SPENCER ETHEL V. EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBRA LENTZ DTR. 5627 SWEET AIR ROAD BALDWIN, MD. 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any Injury o ATLANTIC CREMATORY 9-18-2012 GLEN BURNIE, MD. Signature of Funeral Service Licens 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME. INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) um Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes ∠ □ 9 ☐ Unknown detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 completely filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 2 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, 28c. Injury at Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of ertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day GOWARD SCICCHITANO September 12:57P ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2525 Pot Spring Rd. Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 178-24-3591 1 X M 2 🗆 F 81 10/16/1930 Pennsylvania r then "neturel", or items 23a or 28e-f show the Modical Examiner : wat be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Rd. # L-523 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mentai Hygiene. Importent: If Item 27 is marked other then ' Elementary/Secondary (0-12) Research & College (1-4 or 5+) **Engineer** 5+ Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Domenico Scicchitano Rosa Varano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Scicchitano/sister <u>6215 Shannondell Dr. Audubon, PA 19403</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or St. Peter's Cem. 9/22/2012 Mt. Carmel, PA 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nserval Between Interval Retween Immediate Cause (Final Physician/ disease or condition resulting in death) COVDMAIN UCATS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760<Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier D5)445 2011 of person who completed cause of death (Item 23a) (Type, Print) FORECT TURNER 7600 POLEL De suite 311 Terror. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ()9 Robert Lee Scheerer, Sr. 2012 3:17A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County 12219 Jerusalem Road Kingsville Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours (Month, Day, Year) Director 214-20-1333 1 M 2 D F 86 MD 02/19/1926 Usual Residence of Decedent 28a-f shov 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-f st ner must be notified MD Baltimore Co. Kingsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12219 Jerusalem Road 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 🔀 No Specify. White 3 X Widowed 4 ☐ Divorced Specify Year or Dates. Navy the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Department of Health and Menta Important: If item 27 is marked any injury or other ***** မ Jacob Scheerer Barbara Florence Purdham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Dick - Daughter O. Box 43, Kingsville, MD 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) MORELAND MEMORIAL 9/18/2012 BALTIMORE, MD of Fune Signature Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705_BELAIR RD. NOTTINGHAM, MD 21236 23a. Part 1. Inter the disease, ir compl. ations the specific or heart failure. List o 142 or cause on complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine it any, heading to immedicause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Year Pregnant at time of death
Unknown signed by the and to be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica the Hospital or Attending Physician: To Be 26. Place of Death (Check only one) examiner? 2 **N** Other: 1 Inpatient 2 ANOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner o Leath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes eral Director: After filled in by the funer 28d. Describe how injury occurred Tatural iniury 5 Pending Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated HTV 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Bev 06-2011

State

2012

Samuel	Lucas	Smith	
amuei	Lucas	SIIIIIII	

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		- For State Certificate of Death	Reg.	Z U 1 i	2 3020			
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last)	Date of Death Month Da September 1	ay Year 17, 2012	3. Time of Death 0758 hrs			
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 662 Gatestone Street Gaithersburg		4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 224-39-3659 6. Sex 1. Age (In yrs. last birthday) 2 F 26 Yrs. 6. Sex 1. Age (In yrs. last birthday) 4. Age (In yrs. last birthday) 5. Social Security Number 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. For Months Days Hours Min. June 12, 1986 For Months Days Hours Min.						
and show any nce.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg			10d. Inside City Limits 1 X Yes 2 No			
eath with the Maryland items 23a or 28a-f sho ust be notified at once, inneral Director		10e. Street and Number 10f. Zip Code 305 Alfandre Street 20878		Citizen of What Coun				
ter death with ", or items 22 er must be no	-	11. Marital Status 1 X Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Giva Year 12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric		14. Race - Americ White, etc.				
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Tor Dates: 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired) Physical Therapy Aide)	Physical	ndustry			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Media		17. Father's Name (First, Middle, Last) Bryan Ray Smith Susan Ka	rst, Middle, Mai	den Surname)	петару			
MD 212 d 2 should be lth and Ment n 27 is mark numatic even		19a. Informant's Name/Relationship (Type, Print) Bryan R. Smith /Father 19b. Mailing Address (Street and Number or Rura 10101 Grosvenor Place,	al Route Numbe	r, City or Town, State,				
MOF6 Pages 1 tent of It nut: If i	1	1 Burial 2 XXCremation 3 Removal from State Montgomery 4 Donation 5 Other Specify: Sept 20, 2	cember 2012	Oc. Location - City or Bethesda,	Maryland			
	ł	21. Signature of Funeral Service Licensee M01305 22. Name and Address of Facility Robert A. Pumphrey Funeral 300 West Montgomery Avenu 23a. Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-	ie, kockvi	<u>llle, Marylar</u>	nd 20850–2805 Approximate Interval			
Physician Wedical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
tecuted and transit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.						
760, cate be execu physician and he burial - tri		☐ AMENDED 23a,27,28a-f,per me,g932 10-11-12 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery						
). Box 687 the death certification by the attending probed for use as the Physician/		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown		Month D	ay Year			
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cords law requents been	andino		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of S			
FVital Rec Physician: The r this certificate ral director, page To Be Cor	֓֞֟֓֓֓֓֓֓֓֓֟֟֓֓֓֓֟֟֓֓֓֓֟֟֟֓֓֓֟֟֟֓֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓֟֟֓֓	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing H		sidence 6 🗸 Other:	Scene			
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral Contification:		3 Suicide 6 Could not be determined (Specify) Suicide (Specify) Gelling G	Saithers	sburg,MD.	al Route Number, City tone St.			
To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date and	d place, and due to the	cause(s)			
1		29b. Signatúre and title of certifier 29c. License number O.C.M.E.		9d. Date signed (Mon September 18, 20				
H O Know		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MI	D 21223					
Stat Registra	~	31. Date filed (Month, Day, Year) SFP 2 1 2012						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Mary Catherine Thomas Medical 6:43 PM September 16 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Gilchrist Center for Hospice Care more Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Bill. (Month, Day, Year) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Months Min Hours Director 59 212-60-7652 1 M 2 X F 195B Maryland Usual Residence of Decedent or 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Moline Cir 21221 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ hours aftar Maryland 21215-0036 "natural", 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiena. College (1-4 or 5+) 12 Sales Food Service Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Sumame) William Anthony Thomas Sr. and 2 should by Haalth and Meritem 27 is mark Ada Lucille May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Pastor /Sister permit. Page 1 and 2 Department of Haalti Important: If item 2; 1217 Primrose Ave. Rosedale, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ò 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sep 18 injury 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2012 21. Signature of Funeral Service License 22. Name and Address of Facility any Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami usa as tha burlal-trai that initiated events resulting in death) Last Due to (or as a consequence of): ate has baen signed by tha attanding physician page 2 should be detachad for usa איזיייי Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) __ in the past 12 Month Day Unknown conditions contributing to death but not resulting in the underlying cause Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide

Hospital or Attending Physician: The law raquires that tha death certificata be executed Division of Vital Records, P.O. Box 68760 fillad in by tha funeral 24 hours aftar deat Funeral Director: To tha Hosp within 24 hor To the Fune complately fi

Ö		building, etc. (Specify)	City or 1	Town, State)
Medica	only one) 3 Certifying Nurse	ian: To the best of my knowledge, death occurred at the r. On the basis of examination and/or investigation, in my or Practitioner: To the best of my knowledge, death occurred	ODIDIOD death occurred at the time, det	o and close and due to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o
	29b. Signature and talk of certifier	29c. Lic	cense number	29d. Date signed (Month, Day, Year)

D0071282

who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number

Date filed (Month, Day, Year)

67 310

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM# 100, per FH, G932, 1071372012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Valerie Taylor- Allen \$e₩th. 15 Pay 2012 ar 18:36 Medical 4a. Facility Name (*if not institution, give street and number*)
Univ. of Maryland Medical Center 4b. City, Town, or togation of Death
Univ. Examiner 4c. County of Death Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min (Month, Day, Year) 217-70-0076 Director Yrs. 07-10-Usual Residence of Decedent show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attended to Health and Mertial Hygiene. Assurement of Health and Mertial Hygiene. oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho oortant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Edgewood Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3102 Ebbtide Drive 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 Divorced 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Specialist FBI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Taylor, Jr. Lillian Person 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Allen / Husband 3102 Ebbtide Drive, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it cemetery, crematory or other place) 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 Donation 5 Other (Specify) 9/21/2012 Baltimore, MD of Funeral Sand 22. Name and Address of Facility NOIS Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 days Ph sician/ Anoxic Brain Injury disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** End Stage Renal Disease Sequentially list conditions, it any heading to introduce cause. Enter Underlying Examine Due to for as a nonsequence off HIV Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No
9 Unknown for Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Renal cell carcinoma secondary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed plnous Hyperparathyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed' 24 hours after death. Funeral Director: After this certificate 2 No 2X□ No 1 Tyes Yes Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined ò the Hospital Medical 29a. Certifier **Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Sept. 18, 2012 P102324 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Chandni Kalaria 22 S. Greene St., Baltimore, Md 21201

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G931, 9/26/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month IlVester B. 2:53PM Taylor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7310 Catonsville Baltimore Inwood Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 227.30. Director 1 XM 2 □ F Bl Yrs. 25 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Eventiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Battimore Catonsville MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 7310 USA Inwood Menue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗵 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 ack 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Buisness Owner 12th grade NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Arlithia 191 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter Windingbook Road Borden Town NJ Taylor Seanine Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State Date unk 1 Burial 2 Cremation 3 Removal from State Cremation Center Hanover, MD 4 Donation 5 Other (Specify) Sept. 26,2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Service land Road Randallstown MD 21133 81 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (s a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physicien: The law requires thet the death certificate be executed burs efter death.

eral Director: After this certificete has been signed by the attending physiclan end filled in by the funeral director, page 2 should be detached for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 C Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 20 Sinte 200 falls State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1/8, 2012 Charles Myron Turbett 9:45 P Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Forest Hill Health & Rehab Center Forest Hill 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 217-20-1295
Usual Residence of Decedent 1 🗶 M 2 🗆 F 86 April 21, 1926 Pennsylvania or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2X No Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral United States 313 Willrich Circle Unit F 21050 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ò X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Master Electrician Electrical Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file t and Mental F မ Charles Turbett injury or other traumatic Anabelle Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Anna Turbett / Wife 313 Willrich Circle Unit F Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 19, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral CHapel 4 ☐ Donytion 5 ☐ Other (Specify) Forest Hill, Maryland 2012 Air f Funeral Service Licensee 21. Signat Evans Tuneral Chapel & Cremation Service—Bel Air Da 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, luse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PenenTIA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any leading to immediate Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Exami and that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760 resulting in death) Last Physician/Medical attending phy IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL DISEASE Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? colon concer 24a. Was an Jas autopsy COPID certificate 1 Yes 2 No Yes 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗆 No 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 732255

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O^{Mgnth} Elsie M. Thomas 1⁰0^y 20°°2 SCO PA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 109 Diener Pl. #102 Baltimore N/A 5. Social Security Number 220 – 20 – 4893 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Director 1 □ M 2 🛣 F 84 03/05/1928 Virginia Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Diener Pl. 21229 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Housewife N/A permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ David B. Spencer Flora Anna Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5640 Groveland Ave., Baltimore, MD 21215 Alice Tucker(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
on-site Crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Euneral Service Licenses ²ට්ර්පීම්ච්රි^{dd}Hs ්පිම්මිwn Jr. Funeral Home PA which 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Montrolled Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has d in by the funeral director, page 2 performed? ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Certificate: To 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours after of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Direct of Funeral Dir 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature of certifier 29d. Date signed (Month, Day, Year) aw 30. Name and add completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 9 310 P 201 Medical or Location of Death **Examiner** Town 4c. County of Death N/A LORE If Under 24 Hrs. 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **K** M 2 \square F Months Days Hours Min 213-18-0537 88 MD Director Jan 25, 1924 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
 Bart: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 Wyanoke Avenue 21218 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces?
Yes 2 No10/1/1943 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black If Yes, Give Specify Completed 3 Nidowed 4 Divorced 11/6/1945 Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) **Painter** Self Employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jerry Washington Cora Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ward 7522 Eaglewalk Court, Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Sep 27, 2012 Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) ne and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Signature of Funeral Service Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. 23a. Part 1 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ☐ Yes ☐ Unknown be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 performed this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) PAILHAM woods het BAILMORE, MID 21234 40/InNa

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13 altimone Back Power Rehab Brightwoon v thenville If Under 1 Year If Under 24 Hrs.
Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral 213.20.0628 Director 1 D M 2 M 129 12 141 item 27 is marked other then "neturel", or items 23a or 28a-f show other treumetic avent, the McDoal Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Lutherville Baltimone 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21093-3643 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) 900d Superuison Be permit. Page 1 and 2 should be filec. Department of Health and Mental Hy, Important: If item 27 is marked many injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Button llian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williams Balt. MD 21239 Kobert Son Belvedene 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State crematory or other place. 25/12 woodlawn, MD Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lixinsee 22. Name and Address of Facility Houri lose MO Belain 23a. Part 1. Enter the disease, or c shock, or heart failure. List on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) COROMARY ARTHRY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury HOWK Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month 1 ∐ Yes 2 kg g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 N 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No ျှ 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REITADILITAD POWERDACK State . Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 2012 Year Alfred Nathaniel Williams 9:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiace, Country) VA **Funeral** 1 XM 2 - F Hours 1 172971 946 Director 230-68-1911 65 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature." 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director WV Berkeley Martinsburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 183 Trooper Drive, Apt. 3C 25404 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 2 Yes 2 No Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No 3 Widowed 4 X Divorced Year or Dates. 67-68 Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Baker Rich Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Robert Randolph Williams, Sr. Nannie Randolph Pendleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy V. Brown - Friend 183 Trooper Dr., Apt. 3C, Martinsburg WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Rosedale Cemetery 09/22/2012 Martinsburg, WV 21. Signatu 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Ent. Ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Examiner ner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) as the burial-tran 24 hours after death. Furthis certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Tyes NI HIAMS 25. Was case referred to medical examiler?
1 ✓ Yes 2 ☐ No Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License numbe 012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atwood 32. Registrar' Signatura State

Registrar

400

0

12-06929						
Noreen	D.	Whipple				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 30209

		1- For State Registrar		Cert	fificate of	f Death			Reg.	No.	
Physici		1. Decedent's Name (First, Middl							ate of Death)ay Year	3. Time of Death
ledical Exami	ner	Noreen D. Whip							onth Deptember		1425 hrs
		4a. Facility Name (if not institution 3300 Benson Avenue				4b. City, Tow Baltimo	n, or Location o re	of Death		4c. County of Deat	h
Funeral		5. Social Security Number	6. Sex 7. Ag	e (in yrs. las	st birthday)	If Under 1			Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		577-62-1846	1 M 2 1 F		65 Yrs	Months	Days Hours	Min.	April 2	29,1947 Co	gn Washington
È:		Usual Residence of Decedent 10a, State 10b, County		10c City 7	Town or Locat	ion					10d. Inside City Limits
ом апу											1 Yes 2 No
Aaryland 28a-f show	ţ	Maryland Baltin	more	ватт	imore	10f. Zip Co	do		1100	. Citizen of What Cou	2121
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed writhin 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	3300 Benson Ave. (DePaul House Apt. 213 21227 United St								nited Stat	
th with tems 23	Funeral	11. Marital Status 1 X Never Married 2 Married 2	12. Was Decedent				of Hispanic Orig uban, Mexican,			14. Race - Amer White, etc.	rican Indian, Black,
fter dea			1 Yes 2	X No	1	Yes 2 X	No specify:			Specify: Whi	te
ours a	d by	15. Decedent's Education (Spe-	or Dates: cify only highest grade con	npleted)			cupation (Give k		done 16	6b. Kind of Business	Industry
36 in 72 ho han "na lical Es	Completed	Elementary/Secondary (0-12)	College (1-4 or		auring m Regist		g life. DO NOT : se	use retired)		lealthcare	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	E O	17. Father's Name (First, Middle,						e Namo (Fire		den Surname)	
al Hy	BeC	Charles Dana W	•								
212 uld be Ment mark	To E	19a. Informant's Name/Relations			19b. Mailing	Address (rine Mo Route Numbe	or, City or Town, State	e, Zip Code)
MD d 2 sho Ith and n 27 is		Jean Barnhart	/ Friend		444 W	est Wa	shingto	n B1vd	l Gro	ove City,	PA. 16127
e, le land Healt litem		20a. Method of Disposition			ace of Dispos ematory or ot	ition (Name o	of cemetery,	Dat	e 2	Oc. Location - City or	Town, State
nor ages ent of nt: H		1 Burial 2 XXCremation 4 Donation 5 Other Sp		***	antic		ory	Sent 3	20 2012	Clan Run	nie,Marylan
Baltimore, permit. Pages 1 an Department of Her Important: If ite		21. Signature of/Funeral Service		INCL			dress of Facility			NERAL HOME	
E P P B		fatur an	Warted +	101456	13	28 Su1	phur Sp				land 21227
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death. [Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)				ovascu	lar Dis	sease			Death
		Sequentially list conditions,	b								
5.	ē.	if any, leading to immediate Due to (or as a consequence of): Leading to immediate Due to (or as a consequence of):									
	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							 			
ecuted and - transi			d								
<u>8</u> €	MENDED 23a,pt.II,27,per me,g932 10-2-12 sm FFEMALE: 23c. If yes, outcome of pregnancy 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d. 23d.										
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OX 68 sath certifications or use as								Day Year			
Box 68 e death certif the attending ed for use as	Physiciar	1 Yes 2 No 9 Unk	g Unknown		о <u>г</u> Оп	ilei (opcony)					
O. at the										cco use contribute to	the cause of death?
Cancer (not specified) renal disease								1 Yes	2 No 3 Prol	bably 4 V Unknown	
rds v requ	24a. Was an autopsy per per per per per per per per per per								24b. Were autopsy findings available prior to completion of cause of		
Reco The lav icate hay								ed? death?			
tal Recian: The certificate ector, page		25. Was case referred to medical				26.P	lace of Death (Check only o			2 10
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other ₄	Nursing Hor	ne 5 Re	sidence 6 🗸 Othe	r: Scene
of ing Ph		27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 2	28b. Time of I	njury 28c.	Injury at Work?	? 28d.	Describe how	injury occurred	
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Division of Vital Records, P.O tal or Attending Physician: The law requires that is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detax	Certification:	3 Suicide 6 Could not be determined determined (Specific) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)									ral Route Number, City
		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the within To the comple	Medical	29b. Signature and title of certifie	and manner stated.				cense number			9d. Date signed (Mo	
	-	A 10 1	11/21				.C.M.E.			September 14, 2	
		30. Name and address of person	who completed cause of d	eath (Item ?	(3a)						
		Melissa Brassell, MD	Assistant Medical	Examine	er 900 W	. Baltimor	e Street, Ba	altimore, N	/ID 21223		
St	ate	31. Date filed (MSTP, Pay Year)	2012 32. (egistrai	's Signature	1	v. I					

ORIGINAL

YOUNGER 12-06898 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physiciani 1 Decedent's Name (First, Middle Last) Month Day Y September 12, 2012 OUNGER 0759 hrs **Medical Examiner** HaroLD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Min. Director 214-56-396 9-28 1 VM 2 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Daltimor 28a-f show and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Trove US Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 51a 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene.

If item 27 is marked other than "ther traumatic event, the Medical ? Baltimore, MD 21215-0036 OME for proven 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) asH hert 4 ounger marjorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) Poplar Grove St. Balto, md. Hawanda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State t: If i 1 Burial 2 Cremation 3 Removal from State crematory or other place) -22-12 Wordbine Iruner ponation 5 Other Specify: 22. Name and Address of Facility 3405 WI gnature of Funeral Service Licensee Wallace F. S Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cocaine Intoxication complicating Atherosclerotic **Physician** Between Onset and /Medical a Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g932 10-15-12 sm X UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other: After this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 X No unknown within 24 hours after death.

To the Funeral Director: Director: I in by the f fd 9-12-12 fd 06:00 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 2327 Druid Hill Rd. Baltimore, MD. determined (Specify) Fd: In Residence 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 13, 2012 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Assistant Medical Examiner

rar's Signature

Ana Rubio M.D., Ph. D.

31. Date filed (MonSEP

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rosalyn Ann Ye	ato	1- For State Certificate of Death	2012 3021						
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) 2. D	Reg. No. 2012 30 Time of Death lonth Day Year eptember 15, 2012 3. Time of Death 1223 hrs						
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center 4b. City, Town, or Location of Death Baltimore	4c. County of Death						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Director		219 - 88 - 8515 1 M 2 F 45 Yrs. Months Days Hours Min. C	09/02/1968 Foreign Country) MD						
w any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits						
aryland 8a-f sho at once.	Director	MD Ame Arundel Brooklyn 10e. Street and Number 10f. Zip Code	1 Yes 2 No						
th the M 23a or 2 notified	al Dire	911 E. Patapsco Ane. 21225	USA						
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5-0036 Jed within 7 Hygiene. I other than	Com	17. Father's Name (First, Middle, Last)	t, Middle, Maiden Surname)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once	To Be	Kodar Mathias Falmer (Tatricia 19a. Informant's Tame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Ann Kinehart Route Number City or Town State Zin Code)						
e, MD 1 and 2 sho Health and item 27 is	7,0	Kodger Elmer/Father 18 Camplot Arms Y	ork, PA. 17406						
Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 njury or other traus		1 Burial 2 Cremation 3 Removal from State crematory or other place)	20c. Location - City or Town, State						
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AFA	1stephen D. Lormmenn P.A.						
Physician	100	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp	oiratory arrest, shock, or heart Approximate Interval Between Onset and						
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be es	fedical								
Box 68760 death certificate be the attending physical of for use as the bu	ian/N	23b. Was decedent pregnant in the past 12 months? 25c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year						
P.O. Box that the death ned by the atte detached for u	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown							
			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown						
cords, law requir has been s	Completed by		24a. Was an 24b. Were autopsy findings available prior to completion of cause of						
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f Vita Physicia or this ceral direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Hon	ne 5 Residence 6 Other:						
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To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tand manner stated. 29b. Signature and title of certifier 29c. License number	ime, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
a of our		(Arvange end O.C.M.E.	September 16, 2012						
30.6		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 2	1223						
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeannette Bertha Antonina Wisacki Zukauskas sept. Tags 2^v0°12 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 303 McCormick Street Bel Air Harford County If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number **Funeral** 7. Age (In vrs. last hirthday 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) Director 017-22-9732 1 □ M 2 🕅 E 82 Feb. 25, 1930 Massachusetts 10a. State 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Bel Air 1 Yes 2 No Harford County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 303 McCormick Street 21014 iral", or items 2 Examiner mus 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ced other than " Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Circuit Court of Maryland Be 17. Father's Name (First, Middle, Last) of Health and Mental Hi fitem 27 is marked ot other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) 2 Peter Wisacki Antonia Bluse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Brockmeyer - Gunn (Daughter) 30 Oakwood Ave., Pine Beach, New Jersey 08741 of Healt : If item ? / or othe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

∏ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Manorial Gardens 09/21/2012 Department c Important: If any injury or once. Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air court A 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Kenal disease or condition resulting in death) Failu manths Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number

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State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mp

2. Registrar's Signature

TIMMEY

31. Date filed (Month, Day, Year)

SEP 21

D53186

754 N Hickory Are Ste C Bel Air

September 19, 2012

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 3 Rose Mary Atkins 20T2 12:05 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General Hospital Dorchester 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) Months Days Hours (Month, Day, Year) Country Director 219-74-4868 1 □ M 2 🗓 F 61 Feb. 14, 1951 Virginia parmit. Page 1 end 2 should be filed within 72 hours efter deeth with the Maryland Dapartment of Heelth end Mental Hyglane. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show envinjury or other traumatic avant, the Medical Evan the must be notified at once. 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD 1 X Yes 2 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 Washington Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled did not work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisey Leatch Raymond Atkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Washington Street, Cambridge, MD Pearl Wingfield sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory of Delmarva 9/6/12 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. gnatur of Function Service License 14 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PROBABLE PNEUMONIA Sequentially list conditions. if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examin TRACT INFECTION PROBABLE URINARY To the Hospitel or Attanding Physicien: The lew requires that the death certificete be axecuted within 24 hours after death.

To the Funerei Diractor: After this certificate has been signed by the attending physicien and completaly filled in by the funeral director, page 2 should be deteched for use es the burial-transit attending physicien and for usa es the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) a | | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CIRRHOSIS BILIARY 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manney Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) MD 00068045 SEPTEMBER, 03, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kavita Mohan M.D. 609 Daffin Lane, Denton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

0620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward Milton () Arnie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cambridg If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan 16 Year 1943 New York 1 🛛 M 2 🗆 F 69 212-80-6435 **Director** Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director Cambridge MD Dorchester 1 🙀 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21613 307 East Appleby Avenue or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled did not work Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Tillie J. Arnie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 East Appleby Avenue, Cambridge, MD Tillie J. Arnie mother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 9/6/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ years) disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner bete Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one) completed filled in by the funeral director, Be Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNo 1 Pnpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 🗌 Pending 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only on Certifying Nurse Practioner To the best of my knowledge. at the time, date and place, and dain to the granelet 29c. License number 44445 29b. Signature and title of 29d. Date signed (Month, Day, Year) certifie

Registrar DHMH 17 Rev 7/2009

State

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21613

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. NARR

31. Date filed (Month, Day, Year)

D.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Anderson 5:30p Paul Jay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Transitions Health Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ★ M 2 🗆 F Months 216-38-4377 70 Director 12/2/1941 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shor 10a, State within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Carroll Manchester MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? or items 23a or Funeral USA P.O. Box 62 21102 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 spwhite 1 ☐ Yes 2 X No Specify: marked other than "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Black & Decker maintenance worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Wilmot Sullivan Paul Joseph Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Kay Anderson, wife P.O. Box 62, Manchester, MD 21102 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 18/31/2012 Hampstead, MD . Signature of Funeral Service Lee see 22 Name and Address of Facility Eline Funeral Home M01072 un Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rrhusis Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine day, leading to immedia cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 s 1 ☐ Yes 2 ☐ No Yes 2 - No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 240 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1/2 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only one) 29b. Signature and title of certi-

31. Date filed (Month, Day, Year)

MIIR 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALMOUD

201

32 Bed

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Louise Albright August 28, 2012 7:40 a Medical 4a. Facility Name (if not institution, give street and number) Healthcare Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Lutheran Village Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year, 216-20-2056 **Director** 88 1 🗆 M 2 🗶 F July 18, 1924 Maryland Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at Director 10c. City Town or Location 10d. Inside City Limits Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 St. Mark Way, apt 424 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Completed WWII white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Manufacturing Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry L.B. Parlett, Sr. Louise Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Harmon, niece 5876 York Road, Spring Grove, PA 17362 other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter Scholator) or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 8/29/2012 Winfield, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 29a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final and Death Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any country to in a solution cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 O Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) Other: Certificate: To 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: A
completely filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 K Certifying Physician: To t est of my knowledge, death occ 2 Medical Examiner: On e basis of examina of and/or investication 29a. Certifier We time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Protitioner: To the be ccurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person whicompleted au of de e. Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month UQUST Day Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death HOSPITA topkins Imore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Greece 3 / 0 th / 4 96 8 212-73-6653 44 **Director** 1 🗆 M 2 🔀 F 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20878 USA 1010 West Side Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces , or Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Hair Salon Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgia Stamou Dimitrios Grigoropoulos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dimitrios Grigoropoulos/ 1010 West Side Drive Gaithersburg, Md 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
All Souls Cem. 1 🗷 Bunal 2 □ Cremation 3 □ Removal from State injury or 9/05/2012 Germantown, Md 4 ☐ Donation, 5 ☐ Other (Specify) uneral Service Licens 21. Signature of PHILIPADERINALDI FUNERAL SERVICE, P.A. Wh 9241 Columbia bLvd.Silver Spring, Md 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month signed by the at id be detached for P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records, Completed 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 5 Pending Division 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) ess of person who completed cause of death (Item 23a) (Type, Print) Schiavi MI Orleans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 2012 Registrar

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

SEP 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>012</u> Month Physician/ Eileen Fanning Aukward 30. а м 6:30 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington Park Nursing Home Kensington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 579-20-1777 1 □ M 2 🖾 F 89 Feb. 24, 1923 NC 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

vitem 27 is marked outher than "netural", or items 23a or 28a-f show offer treumatic ovent, the M. Sice Examinar must be notified as 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes XX No MD Silver Spring Montgomery 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 10317 Parkman Road 20903 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Garry Thomas Fanning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10317 Parkman Road, Silver Spring, MD 20903 Mary Anne Marcot/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date . Page 1 permit. Page 1
Department of
Importent: If it
eny injury or o Sept. 2012 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring ,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Con estive Heart Failure Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence off attending physicien and for use as the consideransit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 2 🗌 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 🔯 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) injury 1 K Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examine
3 Certifying Nurse On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ctitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D53691 August 30, 2012

Registrar

State

30. Name and address of person who completed car

SEP 04

2012

Ajay Reddy, MD

\$200)Tower Oaks Blvd., Suite 110, Rockville, MD 20850

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30221 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 08/28/2012 Physician/ Month ERMA V. ALSTON 2048 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days (Month, Day, Year) Director 078-50-5373 1 ☐ M 2 F 56 10-04-1955 GA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery Gaithersburg 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8135 Morningview Drive 20877 death v 11. Mantal Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 ▼ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4 or 5+) Retail 12th Retailer-Dept Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otis B. Jones Narva L. Fountain permit. Page 1 and 2 shot.
Department of Health and
Important: If item 27 is m
any injury or other trans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel L. Nix III/son 8710 Cameron St., #1212, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 9/1/2012 4 Donation 5 Other (Specify) Germantown, MD 21. Signatur of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home Dearge 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death cell lang Physician/ 5mall non disease or condition resulting in death) 1eavs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burlattans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonan 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown preumonit 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |요 1 Nanpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Per Funeral Director: Af oletely filled in by the fu ☐ Accident ☐ Suicide Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completely fi 29a. Certifier only one) 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) August 30,2012 D26540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Gaithersburg, Montal 20877 16220 5 choen berger, MO

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) SEP 0 4 2012

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3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 3 2012 Physician/ Dorothy Arrington Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4b. City, Plata Medica Civista Conter -0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 225–28–6733
Usual Residence of Decedent 1 □ M 2 🔀 F **Director** March 20, 1922 Virginia 90 items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director Maryland Charles Indian Head 1 ☐ Yes 2X No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral U.S.A. 20640 5565 Indian Head Hwy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-6036 1 Yes 2 No Specify. If Yes, Give Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Hensley Walter Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16082 Kings Hwy., King George, Va. 22485 Shelley Wathen Grand daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 6^{Date} 2012 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Manassas, Virginia Stonewall Memory Gardens 4 Donation 5 Other (Specify 21. Signature of Funeral Ser 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, 20640 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liture. List only one cause on each line. art 1. Enter the Approximate Interval Between Onset and Death shock, or Immediate Cau Physician/ Preumoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to or as a conse uence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death the hed Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ျ 1 Mnpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical l 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Dav. Year) 069566

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State Registrar 31. Date filed (Mo

MichelMDS Garrett Avenue, La Plata, MD 20646

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#10e.perfuneraIhome9/7/2012/cchd/ba, Certificate of Death Reg. No For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month Year Alford Mae 08 :55 AM Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Himore If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 6. Sex Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 1 □ M 2 F Months Min 1/27/19//1923 Virginia 88 212 26 6081 Yrs. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits **Funeral Director** MD Baltimore 1 Yes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 3422 21213 USA Lyndale Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emma Wesley Joseph Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3318 Oxon Run Rd S.E. Washington DC 20032 19a. Informant's Name/Relationship (Type, Print) <u>Dartagnan</u> Henley 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pla Garrison Vet. 1 Burial 2 Cremation 3 Removal from State Cem 09/12/12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd Waldorf 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final to (or as a Insequence Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner 471 Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed pona After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a conse resulting in death) Last Jence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 4 Pregnant a Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ART-1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed Shode 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director; completed filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Frectioner: It is to still my new by a carbon or mind of the firm. Set and set and place, and the new by and manner as after. 29a. Certifier (Check 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 2 073321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parhille, HD Walther Woods load 8813 31. Date filed (Month, Day State 212 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie Mabel Braswell Month © 9 Day O4 Medical 0155 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Morchester General Hospital Cambridge rlovelester Social Security Number **Funeral** 8. Date of Birth Aug • 16 • If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 212-18-6527 Days Hours **Director** 89 1923 Maryland Usual Residence of Decedent 28a-f shov death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Dorchester Secretary 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 130B South Street 21664 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic pages 44.0. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Edgar, Sr. Mabel Augustus Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen McMurphy/Daughter O. Box 231, Secretary, MD 21664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery : 9/7/2012 Beulah, Maryland 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, 21. Signature of Funeral Service License Enter the disease, or complic tions that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one called a chiline. and Enter the disease, or complicing shall, or heart failure. List only one of Approximate Interval Between Immediate Cause (Final Physician/ 'erborated verticulation Inset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' ☐ Yes 2 🗙 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death I Director: After t d in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ithin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner within To the only one opportunity at the time. Note and plate, and use to the dause(s) and mainer as stated. 29b. Signature and title of certifier License number 43238 30. Name and address of person who completed cause of death (Item 23a) (Type/Print)

100 Dramble St. Mel Cambridge, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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SEP 9 6 2012

istrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of M	laryland	•			Mental Hy	/gien	e	0 0	2005
		Registrar 1. Decedent's Name (First, Middle,	Last)		Certific	ate of L	<i>Jeath</i>	2. Date of De	Reg. N	o. 201	$\frac{2}{13}$	ne of Death
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Examine		4a. Facility Name (if not institution,			4b. C	ity, Town, or	Location of Death	1	40	c. County of De	eath	
Funeral			6. Sex 7. Ac	u Se ge (In yrs. last	birthday) If Ur	EUS nder 1 Year	TON If Under 24 Hrs.	8. Date of Bi	rth	Ta16	Birthplace (St	ate or Foreign
Director		218-34-75 63	1 □ M 2 🗗 F	96	Yrs. Mont	hs Days	Hours Min.	May 1	ay, Year)	- La . C	lary	
and show Lat	è	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location						10d. Insid	de City Limits
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after d	ह्र	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give	No		pecity Cuba s 2 No	n, Mexican, Puerto Specify:	o Rican, etc.)		Black, Wh		_
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and 2 should be filed within 72 hours aftr Health and Mental Hygiene. em 27 is marked other than "natural", ther traumatic event, the Medical Exar	잍	Abraham	Cooper				EMA	^	SK	in5		
shoul		19a. Informant's Name/Relationshi			19b. Mailing Add		and Number or Ru	_ ,			1	
Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event,	ł	Doretha 20a. Method of Disposition	Gibson		e of Disposition (Vame of		Easto:	1/	ocation - City		601 te
Page 1		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		Para	etery, crematory	1	ery 9/	8/12	Tr	appe.	Mary	land
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	censee	1,001	22. Name	and Addres	sor Facility neral l shington	Home, P.	4.	· \		
402 00	\dashv	23a. Part 1. Enter the disease, or o	complications that cause	d the death. D	o not enter the m	ode of dying	s hingtor g, such as cardiac	or respiratory a	mb)	ridge/	Approx	1613 cimate
Physician/		shock, or heart failure. List on Immediate Cause (Final disease or condition	ally one cause on each lin	e. L f. 1	1110 - H	0-46	vive.				Interva	I Between and Death I 115
Medical Examiner		resulting in death)	Due to (or as	a consequen	/	- ((., , , ,					L
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e deatl the atl) Sici	in the past 12 mg/hths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	at time of deat	th 5 🗌 Other	(specify)				Month	Day	Year
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	<u>چ</u> ا	Part II. Other significant condition			4 . 1	1	en in Part I.	23e. Did t	tobacco	use contribute	to the cause	of death?
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To the within To the comp		29b. Signature and title of certifier				29c. License	number		29d. Da	ate signed (Mor	nth. Dav. Year	7)
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-60		30. Name and address of person w	the completed cause of a	leath (Item 23	(Type, Print)	508	Idlawild	Aveni	re	2ashin	MD	21601
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year David A. Barcroft 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min (Month, Day, Year) Country) **Director** 1 🔀 M 2 🗆 F 535-50-0269 55 10/18/1956 WA 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland "naturel", or items 23a or 28a-f sho 10d. Inside City Limits Director 1 Yes 2 X No MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 350 S. Houcksville Rd. 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married l ☐ Yes 2 🔀 No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ent: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MD State Trooper MD State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Barcroft Jean Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2:
Department of Health
Importent: If item 27
eny injury or other tr.
once. Ann Barcroft, wife 350 S. Houcksville Rd., Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 8/28/2012 Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home 934 S. Main St Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) GPW Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending to processive within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician.

To the Funerel Director: After this certificate has been signed by the ettending physician.

Completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 1 Yes 2 q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence Dovettous မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of th 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred HOSPICE Certificate: Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a title of certifie 29d. Date, signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone filed (Month, Day, Year) 32 Registrar's Signature State **AUG 28** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death September 2, Physician/ 2012 2:00 p^M Theodore Boltz, Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles LaPlata 103 Redbud Crt. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min 207-07-7326 92 Director 1 x x M 2 □ F Yrs Jan. 24, 1920 PA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director LaP1ata 1 🙀 Yes 2 🗌 No MD Charles 10f. Zip Code 10g. Citizen of What Country? o 10e. Street and Number 23a Funeral 103 Redbud Crt. 20646 USA within 72 hours after death with "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mential Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Researcher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul T. Boltz Sara Gehman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5823~Oakland~Park~Dr.~Burke,~VA~2201519a. Informant's Name/Relationship (Type, Print) Terrence Costello/Son-In-Law 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

MD Veterans Cemetery 1

Removal from State

1

Removal from State 9/13/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Arehart-Echols Funeral Home, PA 21. Signature of Funeral Service Licenses MO0945 Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tav disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examir -tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical requires that the death certificate be P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hnknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? After this certificate has 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 2 No ျှ 1 Inpatient 2 I ER/Outpatient_3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of D Ath 28d. Describe how injury occurred 28c. Injury at Certificate: Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 \square Pending 1 Yes 2 No Investigation Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 5, Day 2012 Year Physician/ 9:45 рм John Clifton Blaine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Upper MArlboro 10410 Old Indian Head Rd. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 578-36-8111 82 1 🖾 M 2 🗆 F Director 8/22/1930 Washington, DC Yrs Usual Residence of Deceden shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director r 28a-f sł notified 1 Yes 2 X No Upper Marlboro Prince Georges 10f. Zip Code 0 10e, Street and Number 10g, Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20772 USA 10410 Old Indian Head Rd. 12. Was Decedent Ever in U.S.
Armed Forces?
1 △ Yes 2 △ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3XXWidowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Book Binder 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other thother traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton William H. Blaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10410 Old Indian Head Rd. Upper Marlboro, Md. 20772 Kelly DeGraff/Trustee item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date ō cemetery, crematory or other place, 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State = 5 Department of Important: If any injury or once. 9/14/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, PA P.O. Box 567 LaPlata, Md. M00945 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Heart Disease Sequentially list conditions, Examine one to for as a panse signer of if any, leading to immedicause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Month Day Year Pregnant at time of death 2 No be detached 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has performed? 2 No 1 🗌 Yes 1 ☐ Yes 2xxx No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 K No ၉ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, D12906 person who completed cause of death (Item 23a) (Type, Print) Louis Kaufman 12070 Old Line Center, Suite 207 Waldorf, Md. 31. Date filed (Mont gistrar's Signature Registrar

			Pleas	e Type or P						•		_	ble.	
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Physiciar Medica		Rose	Mary 1	Briscoe						Month 08/30)/20	^{ay} 012	Year	4:48pM
Examine		4a. Facility Name (if no	_				4b. City, Town,			1		c. County o		
Funeral		5. Social Security Num		er Drive		ast birthday)	Lexir			8. Date of Bir		st. I		ace (State or Foreign
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death items ner m	F.	11. Marital Status		12. Was Deceden		S. 13. \	Was Decedent of f Yes, specify Cul	Hispanic Ori Dan, Mexicar	gin? (Spe	ecify Yes or No- Rican, etc.)	-	14. Race	- America White, et	
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	ted by	1 😿 Never Married 3 □ Widowed 4	Divorced	If Yes, Give Year or Dates.	XNo		1 ☐ Yes 2 🙀 N					Specify:]	3lac	k
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d be filed Mental Hy arked oth	To Be	17. Father's Name (Fire George								e (First, Middle, na Bro		Surname)		
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		19a. Informant's Nam Eric Dev					ng Address <i>(Stree</i> 2 Laria							ode)
e 1 an t of He If item or othe		20a. Method of Dispos		☐ Removal from Sta	te C	emetery, cren	osition (Name of matory or other pl			Date	l	Location - C		
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permi Depai Impo any ir		21. Signature of Fune	ral Service Lice	BUSEDE	In									al Home MD 20601
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Medical Examiner		resulting in death)	•	Due to (or a	s a consequ	uence of):								
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pr in the past 12 mc 1 Yes 2 9 Unknown	onths?	23c. If yes, outcom 1 ☐ Live Birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 🔲 Feta t at time of c	al death 3	Ectopic pregna Other (specify)	ncy				23d. Date Mont		y Day Year
that the	by Ph	Part II. Other signific	ant conditions	contributing to death	but not res	ulting in the u	inderlying cause	given in Part	I.	23e. Did t	obacco	use contrib	ute to the	cause of death?
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ending eath. or: Aftu	ficat	2 Accident	5 ☐ Pending Investigati		/ay, rear)	injury		rk? Yes 2	No No					····
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	28e. Place of I	njury - At ho etc. (Specify		eet, factory, office			28f. Location (City or Tou			or Rural F	Route Number,
Hospit 24 hour Funera	edical	(Check 2 L	Medical Exa		f examination	n and/or invest	tigation, in my opi	nion, death o	ccurred at	t the time, date	and plac	e, and due t	o the caus	se(s) and manner stated.
To the within To the compl	Σ	only one) 3 L 29b. Signature and titl	- 4	urse Practitioner: To	the pest of the	ny knowledge		se number	ite ai iu pia	ace, and due to		ate signed (
1		Den	W.	M.D.			36	3885	16			9/5	112	
pa-1		30. Name and address		completed cause of	death (Item	23a) (Type, F	PITAL. 20	500 811	7100k	COUT RA	1. 182	WARD7	δων.	MD-20650
State Registra		31. Date filed (Month		2012 32. fegis	trar's Signat	ture.	ares		, J. C. J.		7		7	2,2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death 12:10 PM Bessie 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Hours (Month, Day, Year, 249-76-7665 74 1 🗆 M 2 🗶 F Oct. 15, 1937 South Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Hyattsville Prince George's 1 X Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 20782 USA 1376 Road Chillum Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: **Black** 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Private Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) Darby 0dessa Moore Earnest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chillum Rd., Hyattsville, MD 1376 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Harmony Memorial Park 09/14/2012 Hyattsville,MD 22. Name and Address of Facility Jordan Funeral Service, CC0341 Washington, DC 20019 4001 Benning Rd., N.E., it cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. Approximate Interval Between Onset and Death Due to (or Due to lor as a consequence of Due to (or as a consequence of):

or 28a-f show ms 23a or 28a-f sho must be notified at Director 10e. Street and Numbe Funeral items be filed within 72 hours after death 11. Marital Status Examiner or. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical I Hygiene. other than " Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) n and Mental | ပ 19a. Informant's Name/Relationship (Type, Print) Albert S. Booker 20a Method of Disposition Department of Important: If it any injury or o once. permit. Page 1 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or of shock, or heart failure. List only o Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any course is a limit cause. Enter Underlying Cause (Disease or injury Examine use as the burial-tran that initiated events resulting in death) Last and the attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Day Month Year Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Tyes ဂ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) of certifie 29d Date signed (Month, Day, Year) Signature and 10 12:05 JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD arroll Registrar's Signat State Registrar DHMH 17 Rev 06-2011

Physician/

Medical

Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9 - 8 - 2012 Mary Frances Black 11:45a M Medical 4a. Facility Name (if not institution, give street and number)
12507 Big Pool Rd b. City, Town, or Location of Death Clear Spring, **Examiner** 4c. County of Death Washington If Under 1 Year If Under 24 Hrs. . Social Security Number 219-60-4657 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 5 - 2 1 Day 1 9 5 2 Maryland 60 **Director** 1 □ M 2**X** F Yrs iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Clear Spring 1 Yes 2 XNo 10f. Zip Code 21722 10e. Street and Number 12507 Big Pool Rd. 10g. Citizen of What Country? Funeral U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 nan "natural", o Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. public schools life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the instructional assistant 12th grade 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ruth Shirk ၉ James Myers 19b. Majling Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 12507 Big Pool Rd. Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) Douglas W.Black spouse and 2 s Health ortant: If item 27 injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Smithsburg, MD 9-14-2012 of O 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crem Department Important: If any injury or Signature of Funeral Service Licer 22 Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Part 1. Enter the disease or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ no Tro disease or condition Years Medical resulting in death) Due to (or as a consequence **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown Division of Vital Records, P.O. been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed **Director:** After this certificate I d in by the funeral director, pag 2 No 2 [Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 41667 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Mor

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar		State of M	larylan		artmer <i>rtificat</i>			and M		giene Reg. N	201	2	30232
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		Medic	al	Robe		lliam ve street and number)	Boura	assa	4b. City	. Town, or	Location	of Death	Sept		ay Ye 2012 c. County of E	Death	1758 [™]
- 9	j	Examili	ei	Subur	ban Hos	pital			,	Bet	hes	da			Montg		
	H	Funeral Director		5. Social Security N 455-66- Usual Residence	4041	Sex 7. Ag 1 🛣 M 2 □ F	ge (In yrs. Ia 67	as <i>t birthday)</i> Yrs.	If Unde Months	Pr 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird 1 0 7 0 2		44	Birthp Count Ma 1	lace (State or Foreign ry) Lne
		faryland 8a-f show tified at	rector	10a. State MD	Montgo	mery		y, Town or Lo ilver		ing						1	0d. Inside City Limits 1 Yes 2 No
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	and 21	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	To Be C	17. Father's Name		1iams		COIN	. 5110	P O	18. Moth	er's Name	e (First, Middle,		n Surname)	115	
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pm a	Baitimore, Maryland	age 1 and 2 sent of Health sent of Health sent. If item 27 y or other tree		20a. Method of Dis	sposition	Removal from Stat	20b. F	Place of Disponentery, cre	osition (Na matory or	me of other plac	e)		Date / 2012	20c. l	Location - Cit	y or To	wn, State
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Ourassa 1788.Pm	NVISIO	all or Atten safter deal Director: d in by the	ပြီ	3 Suicide 4 Homicide	6 Could not	be 28e. Place of Ir	njury - At ho etc. (Specify	ome, farm, st					28f. Location (City or To	Street a wn, Stai	and Number o te)	r Rurai	Route Number,
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91016		Vithii To the the	-	29b. Signature and	d title of certifier	Sic	Siva		29	c. Licenso	6 5 3 (2		29d. E	0ate signed (<i>N</i>	1onth,	Day, Year)
•				- / /		o completed cause of				orac	+01.7~	. ם	Bethe	207-	. ма	202	14
	E	Sta Registr		31. Date filed Mor		32. Regis	trar's Sign	ture	Mad.	orge	LUWI	ı KU	Derile	suc	a, ma	_ 00	1.3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Marguerite а м Elizabeth Bonner September 2012 5:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Village Silver Spring P.G. 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Country) 1 M 2 X F Months Hours Min Day, Ye 18. 163-10-7574 Director 96 1915 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖳 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 3118 Gracefield Road, Apt. 108 20904 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🖾 No Maryland 21215-0036 Specifyhite 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Hygiene. other than "natural", 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Alexander Boyle Margaret Colgan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Ferruggiaro/Daughter 3201 Belle Cote Drive, Burtonsville, MD 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🗵 Burial 2 🗆 Cremation 3 🏝 Removal from State SEPT. Mary's Cemetery 4 Donation 5 Other (Specify) St. Stafford Township, NJ 2012 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licenses 500 University Blvd. Spring.MD 20901 W., Silver 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off. ending physician and ruse as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) Pregnant at time of death 2 🙀 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2X N Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No ္ခ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

10

(Check

only one) 29b. Signature and title of

3 🗆

31. Date filed (Month, Day, Year)

Eugenio S. Machado, MD

SEP 0 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D24035

3110 Gracefield Road, Silver Spring,

29d. Date signed (Month, Day, Year)

MD 20904

September 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar AMEND#20a, b, cpe	State of Marylan	id / Depa	artment of	Health a	and M	lental Hy	giene	0.0	1.0	0.0	100	1
	_		1. Decedent's Name (First, Middle, Last)	CFH,9///12;BM,N	to Cer	tificate of	Death		0 D.t1 D.	Reg. No.	20	12	31	123	4
	Physicia	n/	Jack E. Boucher						2. Date of De Month	Day	2012	/ear	3. Time		,
-	Medic		4a. Facility Name (if not institution, give str	reet and number		4b. City, Town,	or Location o		Sept.		2012 County of	Dooth	8:20) 41	_
	Examin	er	Holy Cross Hospita	·		Silver					ontg		**		
-La	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	_If Under 1 Yea	r If Under 2		8. Date of Bir				ace (State	or Foreia	n
	Director		147-24-6365	M 2 □ F 80	Yrs.	Months Day	s Hours	Min.	(Month, Da			Counti	(y)		
	W		Usual Residence of Decedent						Sept. 4	, 193	1		Yorl		_
	/land f sho ed at	ţċ	10a. State 10b. County	10c. Cit	y, Town or Loc	cation						10	0d. Inside (
	Mar 28a- otifie	Director		gomery S	Silver	Spring							1 ∐ Y∈	es 2 🔀 N	0
	th the	alD	10e. Street and Number			10f. Zip Code				10g. Citiz		at Count	ry?		
	th wit	Funeral	9217 Three Oaks Dr		1	2090				US.					4
	r iter iner		11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 	S. 13. V	Vas Decedent of f Yes, specify Cu	Hispanic Orig ban, Mexican	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	1	 Race - Black, 	America White, e			
38	after al", o xam	d by	3 Widowed 4 □ Divorced	If Yes, Give	1	☐ Yes 2 🙀 N	lo Specify:			s	pecify:	Whit	e		
ŏ	atura ical E	Completed	15. Decedent's Educ	Year or Dates.	16a. Deced	lent's Usual Occi	upation		-	16h Kin	d of Busi	ness/Ind	ustry		\dashv
75	an "n Medi	mp	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give F	kind of work done NOT use retire	during most	of workir	ng				t- Hi	Lstor	id
2	withir giene er th		12	College (1-4 of 5+)	Phot	ographe	r			Buil.	ding	s Su	rvey		
b	filed al Hy d oth vent	Be (17. Father's Name (First, Middle, Last)						(First, Middle		ırname)				
<u>la</u>	d be Menta arked	욘	John L. Boucher					Alma	L. Ho	okey					
lar	shoul and is m		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Stree	t and Numbe	r or Rural	Route Numb	er, City or T	own, Stat	te, Zip Co	ode)		
≥ ~	nd 2 lealth m 27		Joan Klein/Sister			Shore R	oad, N	orth	field,						_
Ore	ge 1 a t of F if ite or ot		20a. Method of Disposition	emoval from State Met	ecreto i des	sition (Name of	EV/	9/6/20	12	20c. Loc Alexar	ation - Ci				
ţ	t. Pag tmen tant: ijury		4 Donation 5 Other (Specify)	Lau	rel Me	morial I	Caric	- beb	012	Pomor	1 3 - 1	lew .	erse	y	_
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy inury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	10-	F22 500	Name and Add ancis J Univer	ress of Facility	ins I	Funeral	Home	Inc	i.	MD	20001	
			23a. Part 1. Inter the disease, or complic	ations that caused the deat							Spr		Approxima	ate	
	trynician/		shock, of heart failure. List only one Immediate Cause (Final		. n	maat							Interval Be Onset and		
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ord	/ requ	lete							24a. Was	an			sy findings		=
ec	e has age 2	Completed							auto perf	opsy ormed? 2 K No	dea	ath?	pletion of	cause of	
E	hysician: The lav nis certificate hav I director, page 2	Be C	25. Was case referred to medical			26.	Place of Deat	th (Check		2 € No	1 L	Yes 2	<u>²</u> □ No		\dashv
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of	nding Phy th. : After this e funeral o		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inj			28d. Describe						
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Ö	ital o urs af ral Di		37						-						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Examine)	ian: To the best of my know r: On the basis of examination	n and/or invest	igation, in my opi	nion, death oc	curred at	the time, date	and place, a	and due to	the caus	se(s) and m	nanner sta	ted.
	o the	Σ	only one) 3 L Certifying Nurse 1 29b. Signature and title of certifier	Practitioner: To the best of r	ny knowledge,		t the time, dat ise number	te and pla	ce, and due to	the cause(s 29d. Date					\dashv
	1.2		15/1/	1,01-			5069						2, 2	012	
	12		30. Name and address of person who com	ppleted cause of death (Item	23a) (Type, P										\dashv
			Sirak Lemma, MD	1500 Forest	Glen	Road, S	ilver	Spri	ng, MD	20910)				
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 5 2012	32. Registrar's Signa	ure par	Ked.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alan Roy Bergsten August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) Director 056-28-9656 1 🕱 M 2 🗆 F 78 June 23, 1934 New York Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Russell Avenue, G7 20877 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ð X Yes 2 Yes, Give 1 🔀 Yes 2 🗆 No/1960— If Yes, Give1/17/1960— Year or Date**s1/16**/1960 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Civil permit. Page 1 and 2 should be filed
Department of Health and Mental Hys,
Important: If item 27 is marked
any injury or other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Lundquist Edwin Bergsten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Jarman/Daughter 18816 Liberty Mill Rd., Germantown, MD. 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 🗹 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 09/01/2012 Alexandria, Virginia nature of Funeral Service Licer 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ neumonia disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner weeks cardiomyorati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of ettending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗹 Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 🖫 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA after death.

Director: After this 124 hours after death. e Funeral Director: After this eletely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 SAL A Bal August 31, 2017 53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Fel., # 213, Gaithersburg, Many Joseph A Ball, MD

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) SEP 0 5

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August

Alon

BER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 30236 Certificate of Death Registra MEND#26perMF, 9/5/12; EMW, McCo Rea. No 2. Date of Death 3. Time of Death Month 8 Day Physician/ 2012^e 25 6:28 A M Carlton Francis Barnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Director 577-50-0183 74 1 **X**M 2 □ F 10/09/1937 Washington, DC Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🔀 Yes 2 🗌 No Prince Geroge's Springdale MD 10e. Street and Numbe 10f. Zip Code 10a, Citizen of What Country Funeral 20774 United States 3500 LaDova Way items 13. Was Decedent of Hispanic Origin? (Specity Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. , or ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 X Yes Baltimore, Maryland 21215-0036 If Yes, Give 1962 7 Year or Dates. 1 Yes 2 No Specify Specify: Black "natural", Completed 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Armed Forces than College (1-4 or 5+) Il Hygiene. Elementary/Secondary (0-12) the Institute of Pathology Lab Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, th and Mental H
27 is marked of
traumatic ever ပ Cecelia Jones Milton Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Lisa Lewis - Daughter 3500 LaDova Way, Springdale, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 8/31/12 1 Burial 2 Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service bicense 5/ mes 7400 Georgia Ave., N.W. Washington, D.C. 20012 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease, or on shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atherosclerone neart disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** disease renal stage Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sums squeries or, To the Hospital or Attending Physician: The law requires that the death certificate be executed diabetes physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as nding puse as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MRSA septicumia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/25/12 72207

State Registrar 31. Date filed (Month, Day, Year, SEP 0

Takoma

egistrar's Signatu

Park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA Beth ANSAIdo, M.D.

20912

MD

12-06561 Nicholas Bruck Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Nicholas Bruck		1- For State Registrar		ate of Maryl		ertificate o		and Mer	ntal Hy		eg. No.	201	2 3023
Physicia Medical Examir	ın/	1. Decedent's Name Nicholas								Date of Dea Month August 31	Day	Year	3. Time of Death 0616 hrs
		4a. Facility Name (i			umber)		4b. City, Towr	, or Location		August 31		County of Dea	th
<i>t</i>				w Medical Cer			Baltimor					ltimor	
Funeral Director		5. Social Security N 246 52 94	05	6. Sex	7. Age (In yrs.	last birthday)		Year If Und Days Hour		8. Date of Bir		Fore	irthplace (State or ign Yugoslavia ountry)
any		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Loca	tion						10d. Inside City Limits
E	5	MD	Montg	omery	F	Rockvill	.e						1 X Yes 2 No
Maryle 28a-f	Tect.	10e. Street and Nu	mber		•		10f. Zip Cod	le		1	0g. Citiz	en of What Co	untry?
ith the 23a or			mosa F	arm Court		10 I 40 W		850	-i-i-0 / 0			ed Stat	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed		Armed F	2 No	lf `	as Decedent o Yes, specify Cu	ıban, Mexica	n, Puerto R			White, etc.	erican Indian, Black,
ours aff	d b		ducation (Spec	orced If Yes, Give Ye or Dates: cify only highest gra	de completed)	16a. Decede	nt's Usual Occ	upation (Give	e kind of wo			ind of Business	
6 na 72 hc	Completed	Elementary/Seco	ondary (0-12)	College (1-4 or 5+)		nost of working	life. DO NO	I use retired	d)			
-003 I within giene.	E	17. Father's Name	(First, Middle,	5+		Profe	ssor	18.Mothe	er's Name (f	irst, Middle, I		Conomic Surname)	es
215 215 se filec ntal Hy ked of	Bec	Niklaus		,					Bieb			,	
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. a 27 is marked other than numatic event, the Medica	ျ	19a. Informant's Na				\$16.	- '					y or Town, Sta	
and 2 : fealth a tem 27	ŀ	Gilda L. 20a. Method of Disp	nosition		20b	Place of Disno	Mimos sition (Name o	cemetery		t Koc Date		le, MD ocation - City o	20850 or Town, State
Baltimore, permit. Pages I an Oepartment of Hee Important: If ite		1 A Burial 2 Cremation 3 Removal from State George Washington Cem. 4 Donation 5 Other Specify: George Washington Cem. Gate of Heaven Cem. 09/08/2012										lphia,	Maryland
altin mit. P partne portar	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler										s Sons	, LLC
		W. Chit	hon n	Luray	CC0379	51	30 Wise	consin	Ave.	NW W	ashi	ngton.	
Physician dinal		23a, Part I, Enter th failure. List on			aused the deat	n. Do not enter	те поде ог ду	ing, such as	cardiac or r	espiratory am	est, snot	ck, or near	Between Onset and Death
Examiner	-	Immediate Cause (or condition resulting		a. Asphyxia Due to (or as a	a consequence	of):							1
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	Examiner	cause. Enter Unde	rlying Cause	с									
nd die	Exa	events resulting in		Due to (or as a	a consequence	of):							
50, te be executed ysician and burial - transit	ledical	UNPENDED		X AMENDED	#20Ъ-с,	per fh,	g932 10	-1-12	sm				
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	21	IF FEMALE: 23b. Was decedent past 12 months	?	e 1 Live	nant at time of d	2 F6	etal death ther (Specify)	3 Ectop	oic pregnanc	су		Date of delive Wonth	ry Day Year
that the dined by the detached:		Part II. Other signi	ficant conditi			resulting in the	underlying cau	se given in P	Part I.	23e, Did to	obacco u	se contribute to	the cause of death?
ires that the signed by	Completed by	cerebral inf	arction an	d other chronic	natural dise	eases		-					bably 4 Unknown
ords w requi	plete									24a. Was autop	sy	prior to	utopsy findings available completion of cause of
Rec The la	틼									1 Yes	rmed? 2 √ No	death?	'es 2 No
ital Fician:	8	25. Was case referrexaminer?		100	Innatient 2	✓ ER/Outpatien		Other	h (Check on Nursing		Residen	nce 6 Othe	er.
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been so led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director.	٩	1 Yes 27. Manner of Deat	No h		of Injury 1, Day Year) 2012	28b. Time of		Injury at Wor	rk? 2	8d. Describe	how injur	y occurred	
ion trendir leath. tor: A	aţi.	1 Natural 2 ✓ Accident	5 Pend	ling Aug 31,	2012	0000 hrs	1[Yes 2♥	Z NO I	ubject acc be	identai	lly alsloage	d his tracheostomy
Division pital or Attentous after death ours after death teral Director: filled in by the	Certification:	3 Suicide	6 Coule	d not be 28e. Plac		home, farm, stre	et, factory, offi	ce building, e	etc. 2			id Number or R nue, Baltimo	tural Route Number, City
bou hou		4 Homicide 29a. Certifier (Check only 1	CertifyIng Ph	nysician: To the be	-	dge, death occu			lace, and di	ue to the caus	se(s) and	manner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical	2 🖳		miner: On the basis and manner:		and/or investiga				he time, date			
0	2	29b. Signature and	Russla.	11 mil				ense number C.M.E.	1			ember 1, 2	onth, Day, Year) 012
	-	30. Name and address	ess of person	who completed cau	se of death (Ite	m 23a)							
		Pamela E. S	Southall, M	ID Assistant	Medical Ex	aminer 90	0 W. Baltim	ore Stree	et, Baltim	ore, MD 2	1223		
Sta Regist	ate rar	31. Date filed (Mon	EP 04	2012	egistrar's Signa	ture da	Mad.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 00 Physician/ Day | 7 Year 20 Baker . Jr 12 2 AM John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Althor woodland Nursing Home Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 - F Director 579-72-2355 58 July 15,1954 Washington DC 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🖳 No Md. Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 23a 1000 Dale View Drive 20901 U.S.A er than "natural", or items the Medical Examiner mu filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 76-78
Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 X Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) US Navy 12 US Military Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of John Baker, Sr. Iris Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u> Gwen Lassiter - sister</u> Girard St. NE, Washington, D.C 20017 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Natl Cem 8/28/2012 Triangle, Va 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Steven Napper I 22. Name and Address of Facility Eternal Faith Funeral 0684 Southern MD. Blvd, Dunkirk, Md. M0157/6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HENO CARCHADINA COLON WITH METERSES disease or condition yEG17 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MER. WHERE CINTENTIL DISEASE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Region Below knee amputation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe transmetalsul amputation Yes 2 N se referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO1612 August 17 2012

Registrar

State

31. Date filed (Month, Day, Year,

seensbury Rd Hyattsville MD-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 September 11:30 P^{M} John Louis Bugler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehab Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours 340-18-9249 Director 87 1 X M 2 F Jan. 10, 1925 Wisconsin Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director be notified 1 🔀 Yes 2 🗌 No Maryland Frederick Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21701 United States 144 Fairview Avenue must death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. W Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Scientific Programmer Technology Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Marie Schmidts Louis John Bugler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Fairview Avenue, Frederick, MD 21701 Colleen Bugler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Sept. 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the dise shock, or heart failu e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause or Leach line. Approximate ofe and Death Immediate Cause (Final Physician ATTINGNE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last ending physician r use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗆 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one 29b. Signate 29d. Date signed (Month, Day, Year) 20062223 ess of person who completed cause of death (Item 23a) (Type, Print)

EET BOCANUT, 1967JDNEUZ, PREPRIECE, MD 21702 X gistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a per FH FCHD TM 9/10/12

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Mary		tificate of D		ientai mygie Reg.		0 00010
			Decedent's Name (First, Middle, Last)					2. Date of Death	201	2 3. Hine of Beath U
	Physicia Medic		John Edward Bennett	=				August 30	0, 2012 ^{ear}	1:10 P M
-	Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, or			4c. County of De	eath
-			Shady Grove Adventis				ville		Montgo	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In y	78. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. E	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	7 2 4 7	OZ Yrs.			March 7, 1	.930 I1	llinois
	f sho	후	10a. State 10b. County	10c	. City, Town or Loc	ation				10d. Inside City Limits
	Many 28a-	Director	Maryland Montgomery	7	Ger	nantown				1 ☐ Yes 2 🛣 No
	th the	alD	10e. Street and Number			10f. Zip Code	,		Citizen of What (
	ath wi	Funeral	20300 Foxwood Terra	Ace Was Decedent Ever in	13 V	2087			nited St	ates nerican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1		Vas Decedent of His Yes, specify Cubar		Rican, etc.)	Black, Wh	nite, etc.
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yla	Ment Ment narke	욘	Claude Bennett		-1		Gladys K	nipperber	g	
, Maryland	nd 2 shorealth and m 27 is n		19a Jeformant's Name/Relationship (Type Katherine V. Benn Kathryn Bennett /	ert / Wife	1	-		Germanto		
Baltimore,	Page 1 ament of Hant of Hant: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Report Support noval from State	Db. Place of Dispo Rocky ^{cr} G Veterans	sition (Name of patory or other place Cemetery	Sept 20	. /,	c. Location - City intstone	or Town, State , Maryland	
Balt	permit. Depart Import any inj		21. Signatur of Funeral Service Licensee		1 1 1 1 1 1	e\stha√en 501 Catoc	Funeral tin Moun	Services, tain Hwy.	Skkot C Frederi	ody P.A. ck, MD 21701
)	Ph _y si ian Medical Examiner	ər	shock, if heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	tions that caused the ause on sach line. ASIC	sequence of:	r the mode of dying	, such as cardiac c	or respiratory arrest,		Approximate Interval Between Onset and Death
	cate be executed physician and s the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con						
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. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of profile 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	ý		23d. Date of o	delivery Day Year
ls, P.O.	uires that the signed by ald be deta	by	Part II. Other significant conditions copyr	buting to death but no	ot resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
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ital	certifical rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:		Totho	ce of Death (Check	(only one)		-
of V	y Physer this eral di	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatier 28b. Time of	t 3 L DOA 2 28c. Injury	4 🗀 Nursing Ho	me 5 Residence 28d. Describe how i		ecify)
on	ending eath. or: Afte he fur	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	<i>ir)</i> injury	M 1 🗆	Yes 2 🗆 No			
Divisi	al or Atto s after de al Directo ed in by t	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp		eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner only one) 3 Certifying Nurse P	On the basis of examin	nation and/or invest	igation, in my opinio	n, death occurred a	t the time, date and p	lace, and due to th	ne cause(s) and manner stated.
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	34		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type, F	MoleCa	lar B	· Rocki	ville, M	D 20850
i	Sta Registra		31. Date filed (Month, Day, Year) 5 201	2 32. Registrar's S	ignature	arkes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Christopher Paul Buckley 4:36 AUGUST 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES MEDICAL LIVISTA lf Under Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 216-50-8943 Director **™**□M 2 □ F Yrs 63 11. 1949 Washington D.C. Usual Residence of Deceder 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified i Maryland Prince George Accokeek 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16410 Accolawn Road 20607 U.S.A. 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunication Sup. Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Buckley Elizabeth Catherine Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Denise Carson-Bucklev Wife 16410 Accolawn Rd., Accokeek, Md. 20607 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other sept. 5, 2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Funeral Service Alexandria, Virginia Signature of Funeral Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter Approximate Interval Betweer shock, or heart failur Immediate Cause Onset and Death -Physician/ disease or condition resulting in death) ordiac Medical Due to (or as a consequence of **Examiner** youtusive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 1abeti that initiated events resulting in death) Last Due to (or as a consequence of -burial-Physician/Medical 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ó in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 1 Inpatient 2 PER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be after death the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Mirse Practitioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

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CHRISTOPHER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DEBORAH BROWN 21:19 AUG 2013 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER BOLTIMOR **Funeral** 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 579-68-7169 **Director** 1 □ M 2 🛛 F Yrs. 05/04/1951 DC Ы 28a-f shor 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director must be notified 1 X Yes 2 No Prince Georges Oxon Hill 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1515 Fenwood Ave. 20745 AZU death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 6 Black, White, etc. þ Page 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Completed 3 Widowed 4 Divorced Specify: **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 15 Paralegal Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nathaniel Anderson Annie Mae James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau. once. 1515 Fenwood Ave., Oxon Hill, MD 20745 William A. Brown / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 08/27/2012 Clinton MD Signature of F neral Service Licenses 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd Camp Springs MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 MONTH APPENDICITIS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Pregnant at time of death 5 Other (specify) Month Dav Year Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 2 X No Other: 2 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA S L 4 Nursing Home 5 Residence 6 Other (Specify) s after deam.

al Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1609142819 AUG 2012

Registrar
DHMH 17 Rev 06-2011

State

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31 Date filed (Mc

SOUTH GREENE ST.

BALTIMORE, MD

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMITH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Aug 23, 2012 2:24 P Anna W. Berry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Collington Episcopal Lifecare Community Mitchellville If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🖾 F 97 June 6, 1915 Rockway, Director 081-12-8685 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a State show ral", or items 23a or 28a-f shov Even increust be notified at 1X Yes 2 □ No Director Mitchellville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20721 USA 10450 Lottsford Road #420 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Warner-Lambert College (1-4or 5+) than Elementary/Secondary (0-12) **Pharmacuticals** Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental H Item 27 is marked ott other traumatic even Be Anna Taylor Robbins Charles Herbert Walling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4511 Banff St., Annandale, VA 22003 Pages 1 ar. nent of Heal. nt: If item 27 David C. Berry - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Alexandria, VA Metropolitan Crematory 8/25/2012 4 □ Donation 5 □ Other (Specify) 4739 Baltimore Ave. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Loy 23a. Part 1. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 months Immediate Cause (Final disease or condition resulting in death) Failure to thrive **Physician** /Medical Due to (or as a consequence of) Examiner years Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine years Hospital or Attending Physician: The law requires that the death certificate be executed Zenker's diverticulum sician and burial-tran Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 💆 No 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Iron deficiency anemia Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Carcinoma of the colon autopsy performed? Ves 24 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1∐Yes 2∑XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After 1 Injury s after deau...
al Director: Aft 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 🗌 Homicide within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25079 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20706 8116 Good Luck Rd, Ste 300, Lanham, MD Don H. Yablonowitz 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

7 2012

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ William Edward Belden 11821AM 2092 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 218-90-7172 1 X M 2 □ F 47 March 19, 1965 Cheverly, Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland | Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9311 Fontana Drive USA 20706 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🕱 No If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Arena Liquor Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Elmer Belden Carol Ann Steep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Belden / Mother 9311 Fontana Drive, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/25/2012 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular disease or condition resulting in death) Pulmonary Course tially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury tersion that initiated events resulting in death) Last Due to (dr as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 Yes 2 No 3 Probably 4 Unknown Be 25. Was case examiner မ 27. Manner of Certificate: 1 Natur

or Attending Physician: The law requires that the death certificate be executed the burial-tran physician Division of Vital Records, P.O. Box 68760 ed by the a page 2 should been Director: After this certificate has funeral director,

Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician/

Medical Examiner

should be filed within 72 hours after and Mental Hygiene.

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Baltimore,

filled in by the within 24 hours a

To the Funeral C To the Hospital

Medical

29a. Certifier (Check

29b. Signature

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			24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Was case referred to medical examiner?		26. Place of Death (C	heck only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	g Home 5 ☐ Residence 6 ☐	Other (Specify)
Manner of Death Natural 5 Pending Accident Investigation Suicide 6 Could not be	n	me of jury at work? M 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury o	ccurred
4 Homicide determined	28e Place of Injuny - At home for	m, street, factory, office	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
(Check 2 L Medical Exam	iner: On the basis of examination and/or	eath occurred at the time, date and plac investigation, in my opinion, death occurre ledge, death occurred at the time, date an	ed at the time, date and place, ar	nd due to the cause(s) and manner stated
o. Signature and title of certifier		29c. License number MDD 7207		signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Satyam Vashi, MD. 8118 God

8118 Good heckld., Carham, MD. 20106

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Alice Pear1 Bush 2012 <u>August</u> 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1709 Calais Court Oxon Hill Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 577-46-1524 Months Hours Min 1 □ M 2 👿 F 79 March 6, 1933 Usual Residence of Decedent South Carolina 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Calais Court 20745 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Forces? 1 ☐ Yes 2 🛂 No 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) years Administrative Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Bush Maggie Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston L. Bush, Sr. - Nephew 1517 Ritchie Road Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lincoln Mem Cemetery Sept 8, 2012 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. T. Stewest M00560 4001 Benning Road, NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Uterine Sarcoma Due to (or as a consequence of):

Physician Medical **Examiner**

attending physician

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within 24 hours after death.

To the Funeral Director: After this certificate

filled in by

Certificate:

Medical

certificate be Box 68760

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or Attending Physician:

To the Hospital

P.O. |

Division of Vital Records,

Department Important: If any injury or

Physician/

Medical

Examiner

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Page 1 and 2 should be filed within 72 hours after death wment of Health and Mental Hygiene. Fart I feem 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

with the Maryland

the burial-tran Physician/Medical as nse jo signed k ģ Completed Be ျ

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 L 9 Unknown Yes 2 XNo Failure to Thrive Dementia Decubitus Ulcer

25. Was case referred to medical

Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 👿 No 1 Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 No	Ho	spital: 1 Inpatient 2	ER/Outpatient	з 🗆	DOA Other: 4 Nursing F	Home 5 🕱 Residence 6 🗆 Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М		28d. Describe how injury occurred
4 Homicide determined		28e. Place of Injury - At he building, etc. (Specify		t, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 K Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and due to the	cause(s) and manner as stated.
(Check	2 \(\sum \) Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated
only one)	3 Certifying Nurse Practitioner: To the best of my knowledge, deat	th occurred at the time, date and place, and due to	o the cause(s) and manner as stated.
29b. Signature ar	nd title of certifier	29c License number	20d Data signed (Month Day Year)

MD32485

September 4, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Temketem L. Tsige 700 2nd Street, NE Washington, DC 20002

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

450

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ September 2, 2012 Matilda Ethel Jett Brown 1745 HrsM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 1925 Min. Hours Director 578-26-7483 1 🗆 M 2 🗶 F 87 Yrs February 12, Washington, D.C. 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6424 North Capitol Street, N. W. 20012 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc Ş 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 **Black** 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) District of Columbia if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Recreation Coordinator Dept.of Recreation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jett, Sr. Mildred Malachi Henry West Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print)

Joshua Brown, Sr. (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Jean Brown Williams (Daughter) 12603 Breyer Place;Beltsville,Maryland 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. Sept. 8, 2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Memorial Park Laurel, P.G. Co. Maryland of Funeral Sc 22. Name and Address of Facility R. N. Horton Company Morticians, 101421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Streptococcus Viridans Urinary Tract Infection burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ed by the attent detached for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year 9 I Inknown Division of Vital Records, P.O. The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed I irector, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 K N funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at ne Hospital or Attending Pin 24 hours after death.

ne Funeral Director: After tipletely filled in by the funers 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

To the Hosp within 24 hou To the Funer completely fi

55M

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

only one) 29b. Signature and title of certifier

> 6 SEPA

Alagarsamy Verrappan, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) H01y Cross Hospital

29c. License number

D0067279

29d. Date signed (Month, Day, Year)

September 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 07 Physician/ John Edward Clopper, Sr. 6:28pm 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 214-28-4960 Director 1 XM 2 □ F 79 Nov. 1,1932 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl Maryland Washington County Clear Spring 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a o Examiner must be Funeral and 2 should be filed within 72 hours after death with Health and Mental Hyglene. tem 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b 12810 Kending Lane 21722 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No. 1 Yes, Give Black White etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Business Owner Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry C. Clopper Ruth M. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene E. Clopper-wife 12810 Kending Lane Clear Spring, MD 21722 Department of Health Important: If item 27 any injury or other tr once, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Paul's Cemetery 9-11-2012 | Clear Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diserto (or as a conseq or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RACI 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page CHRONIC ONSTRUCTIVE performed after death.

Director: After this certificate movally disense 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

State Registrar ted cause of death (Item 23a) (Type, Print)

24990DDC

MEDIUM CAMPUS

AmendItems 10f, WCHD/	10 JW	a,10b,10c,10e, 9/18/2012perFH	ease Type o State	or Pri	aryland / Dep	artmeni	of F	lealth a	u re All Copi c and Mental H	es Ar ygien	e Legible	9.
Physicia Medi		Registrar Decedent's Name (First, Mid		FFIN	Ce	rtificate	of L	Death	2. Date of I Month Septer		8, 20 ^{Yea}	3. Time of Death 8:44 a M
Examir		4a. Facility Name (if not instituti 516 Reynolds	-	umber)		Hage	erst	Location o	f Death		c. County of De Washing	
Funeral Director		5. Social Security Number 220-54-2577 Usual Residence of Decedent	6. Sex 1 M 2 S		e (In yrs. last birthday) 63 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. Date of E Min. (Month J August	Birth Day Year)	1949 ^{9. E}	Birthplace (State or Foreign Country) Texas
Maryland 28a-f show otified at	Director	10a, State 10b, Coun	ington		10c. City, Town or L		lin;	gton				10d. Inside City Limits 1xx Yes 2 □ No
h with the ns 23a or ?	Funeral D	10e. Street and Number 516 Reynolds	Avenue 390			South	2174		04-0000	1	Ditizen of What G	Country?
036 's after deat ral", or iten Examiner r	by	11. Marital Status 1 ☎ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	If Von (Forces? s 2 🕱 Sive		Was Decede If Yes, specif	y Cuba	n, Mexican,	in? (Specify Yes or No , Puerto Rican, etc.)	0-	14. Race - An Black, Wh Specify: wh	nerican Indian, nite, etc. Lite
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		dent's Education whest grade complete College	ed) (1-4 or 5	+) (Give	edent's Usual e kind of work DO NOT use i	done d	ation luring most	of working	1	Kind of Busines	ss Industry
land 2 I be filed wire fental Hygierrked other	To Be (17. Father's Name (First, Middle				<u>Januar</u>		18. Mothe	r's Name (First, Middl Doris		n Surname)	
Mary nd 2 should ealth and M m 27 is ma		19a. Informant's Name/Relation	1 1 21 7	er					r or Rural Route Numl e, Hagerst			
Baltimore, Permit. Page 1 and Department of Hea Moortant: If item any injury or other once.		20a. Method of Disposition 1 A Burial 2 Crematic 4 Donation 5 Other	r (Specify)	m State	20b. Place of Disp cemetery, cre Rose Hil	natory or oth	eter	yS		2 Hag		n, Maryland
Bal permi Depart Impor any ir		21. Signature of uneral Service	Vendi		4		t Wi	llson	Blvd., Ha	gers		me aryland 21740
Friysician/ Medical Examiner	87. 1	23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	at only one cause on	each line رسان	the death. Do not en	ter the mode	of dying	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
O s be executed sician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	S c	`	a consequence of): a consequence of):							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be extwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e Birth egnant at	2 Fetal death 3	☐ Ectopic pr ☐ Other (spe		у			23d. Date of o	Jelivery Day Year
ds, P.O uires that then signed by		Part II. Other significant condi	- J	death be	ut not resulting in the	underlying ca	iuse giv	en in Part I.	200. 010			to the cause of death? Probably 4 🗌 Unknown
Record The law requate has bee	Completed by								_ per	s an opsy formed?	prior to death?	autopsy findings available completion of cause of essential Section 2015
Division of Vital Records, P.O. for the Hospital or Attending Physician: The law requires that the within 24 hours after death. For the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	To Be	25. Was case referred to medici examiner? 1 Yes 2 No 27. Mann eath 1 Natural 5 Peni	Hospital: 1 [28a. Dat	Inpatie		of 28	Othe	r: 4 🗌 Nur at	rsing Home 5 Res			ecify)
ivisior after death Director: A	Certificate:	2 Accident Invest 3 Suicide 6 Cou	rminod 28e. Plac		ry - At home, farm, st . (Specify)	m reet, factory,		Yes 2 🗌 1	28f. Location	(Street a		Rural Route Number,
the Hospits nin 24 hours the Funeral	Medical	(Check 2 ☐ Medica on y one) 3 ☐ Certifyi	I Examiner: On the bing Nurse Practione	asis of ex	my knowledge, death kamination and/or inve dest of my knowledge	stigation, in m	y opinio	n, death occ	curred at the time, date	and plac	e, and due to the	e cause(s) and manner stated.
To t with Con		29b. Signature and title of certif	-W1	_	w)	1	2	number 2	?3	29d. D.	ate signed (Mon	eth, Day, Year)
IW-20		\$0. Narde and address of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons of persons	n who completed ca	35	eath (Item 23a) (Type,	Print)	\sim	cdu	ed Can	yr.	i Pel	1 (egerstrun
Sta Registra		SEPI	2012	Sassa	- Originature	Seise						ms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 30 2012 THOMAS LEE CLEMENTS August 1:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth Funeral Age (In yrs. last birthday) Days Hours Min. (Month, Day, Year) Director 230-48-9706 1 🕱 M 2 🗆 F 1939 North Carolina 73 29, Usual Residence of Decedent ir than "natural", or items 23e or 28a-f show the W.d'cel Ex. miner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No MD Prince George's Temple Hills 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 2900 St. Clair Drive, Apt. 311 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Ø No Specily Specify: Black 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Custodian 12 Church t. Page 1 and 2 should be filed witterent of Health and Mental Hygientant: If Item 27 Is marked other 1 jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Graham Clements Lola B. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Greenview Lane, Manassas, VA Lola Mae Clements, Sister Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 🙀 Removal from State Important: It any Injury or Sept 7,2012 4 Donation 5 Other (Specify) Pleasant Valley Mem. Annandale, VA 21. Signature of Funeral Service Licenses

Bunsa () (2) 22. Name and Address of Facility 8914 Quarry Road arnord O A 20110 Ames Funeral Home, Inc. Manassas, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ Medical resulting in death) Due to (or as a consequence of): [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificete be executed use es the burial-traps and Due to (or as a consequence of): resulting in death) Last attending physicien for use es the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched to the funeral director, page 2 should be deteched. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown REVAL FATILURK ACUTE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 19 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 0064986 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

Registrar

SEP 0 5 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G932, 10/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar 30250 Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Nancy Heiskell Clark 30, 2012 11:15 P M Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3806 Leland Street Chevy Chase 579ST4146537 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 076-12-0866 Director 1 M 2 V F 92 Washington, DC 07/08/1920 Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Chevy Chase 1X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3806 Leland Street 20815 United States within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Lewis Heiskell Elaine Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau Nancy Lewis Clark / Daughter 6678 Hillandale Road Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Church Cemetery Fort Washington, MD Signature of Fundral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons LLC. CC0379 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Interval Between Immediate Cause (Final Onset and Death

yrs. Physician/ 2 disease or condition resulting in death) Stroke Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Directo for an a nonnectionne of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 5 Other (specify) Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be c Atrial Fibrillation No 3 Probably 4 Unknown 1 Yes Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 2 🛚 No Other: 1 🗌 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D-23556 August 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5215 Loughboro Road NW Washington, DC 20016 Robert H. Blee, M.D. 31. Date filed (Month, Day, Year) State SEP 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra AMEND#20boerFH, 9/7/12; BMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WENDELL 2012 CHAPIN 11:45PM Medical AUG 4a. Facility Name (if not institution, give street and number WALTER REED Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL MILITARY MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) Social Security Number Funeral If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months Hours Director 381-12-1712 1 XM 2 □ F 90 MAY 12, 1922 MICHIGAN Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √2 Yes 2 □ No D.C. NONE WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3700 NORTH CAPITOL ST. N.W. 20011 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗀 No. 1945. If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 1968 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 U.S. AIRFORCE DEFENSE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PETER CHAPIN FAY CARPENTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. GILBERT/DAUGHTER 1601 CUYLER BEST RD., APT. E5, GOLDSBORO, NC 27534 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT'L. CEM.9-28-2012 ARLINGTON, VA. . Signature of Funeral Service Licenses CHAMBERS TONERAL HOME & CREMATORIUM, P.A. MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 🗌 Yes 2 🔯 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 🗌 No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of STAFF INTERNIT 29c. License number 29d, Date signed (Month, Day, Year) MPH AUG 29 2012 NE 20315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER WILLIAM T. SHIMEALL, MD BETHESDA, MD 20889

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of N	1arylan		artment of		and M	1ental Hy	giene	001	0	0005	~ ^
			State Registrar				Cer	tificate of	Death			Reg. No. 2	201	2	3025	<u> </u>
	Physicia Medic		1. Decedent's Name		an, Cre	ight	tη				2. Date of De Month	ath Day	28 Yes	er Loi 2	3. Time of Deat / 75/	.h M
)	Examin				re street and number)	Cent	rev	4b. City, Town, o		of Death		4c. C	ounty of D	eath		
	Funeral Director	-	5. Social Security Nu 213 33 92	ımber 6.		ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir 6/4/19	th av Year)	g.	Birthpla Countr	ace (State or Fore	eign
	200	L	Usual Residence of		I LANVI Z LI F Z	,	Yrs.	cation	<u> </u>		0/4/17	71			d. Inside City Lin	nits
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	vith the 23a or st be n	eral D	10e. Street and Num 410 Coul		Lane			10f. Zîp Code 2186	3		İ	10g. Citize	en of What	Count	y?	
36	after death v il", or items xaminer mu	d by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Married	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give			Nas Decedent of Information of Yes, specify Cub	an, Mexicar	n, Puerto			Race - A Black, W	hite, et	c.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Industrial: I fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		15. Decedent's cify only highest o	Year or Dates. Education grade completed) College (1-4 or	5+)	(Give	dent's Usual Occu kind of work done O NOT use retired	during mos	t of worki	ing		d of Busine			
	e filed wil Ital Hygie ed other event, tl	ത	17. Father's Name (F)		Scaac	110			e (First, Middle,	. Maiden Sui				
Maryland	should be file and Mental F is marked o raumatic eve		Robert Ca				10b Mailir	ng Address (Street			n Johns		uun Stota	Zin Co	ida)	
	d 2 sh ealth ar 7 is er trau	- 2		•	andmother)		I.	oulbourn							40)	
Baltimore,	age 1 and ent of Heal nt: If item 3				Removal from Stat	e c	cemetery, cren	sition (Name of natory or other pla te Crema			Date 2 0 1 2	20c. Loca Mills	ation - City			
Baltir	permit. Page 1 a Department of the Important: If ite any injury or of once.		21. Sign Tire ur			0-		2. Name and Address 108 Will	ess of Facilit	ty Th	e Burba	ge Fu	neral			
			23a. Part 1. Enter f	ne disease, or co	mplications that cause one cause on eagh b	d the deat	h. Do not ente				-			1	Approximate nterval Between	
	Physician/ Medical	х 9 0	Immediate Cause (I disease or condition resulting in death)	Final	Anox	i`c .	Brown	Injury	2		-11	Charles of the	F. /		Onset and Death	
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09	ite be executed hysician and the burial-transit	dical Examiner	resulting in death) L	Last	Due to (or as	s a consequ	uence of):			Ø.						
9289	rtificate ling phy se as th	/Med	IF FEMALE:		23c. If yes, outcom	o of progna	anov.				-					- 7
. Box (Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director, After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/Me	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	1 Live Birth 4 Pregnant 9 Unknowr	2 Feta at time of o	al death 3	Ectopic pregnar Other (specify)	ncy			23	Id. Date of Month		y Day Year	
ds, P.O.	requires that the been signed be should be deta	by	Part II. Other signif	cant conditions	contributing to death	but not res	sulting in the u	inderlying cause g	iven in Part	l.					cause of death?	
Records,	sician: The law recertificate has be lirector, page 2 sh	Completed									24a. Was auto perfi 1 \(\sum \text{Yes}		prior death	to com	sy findings availa pletion of cause	ble of
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of V	ding Phys h. After this funeral d	te: To	27. Manner of Death		28a. Date of in	jury	ER/Outpatier 28b. Time of injury		ry at	4 1	ome 5 Resi 28d. Describe			pecify)		
ion	uttendir death. stor: Af y the fu	Certificate:	2 Accident 3 Suicide	6 Could not	on 08/22	12012	unknow	n M 1	Yes 2	No	Subject		-			
Division of Vital	tal or Attend ins after death al Director; A lled in by the f		4 Homicide	determine	building, e	tc. (Specify	V)	eet, factory, office			28f. Location (City or To	wn, State)	number or	HUrai F	route Number,	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of urse Practitioner: To the urse br>urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse urse	examination	n and/or inves	tigation, in my opin	ion, death o	ccurred at	t the time, date	and place, a	nd due to t	he caus	e(s) and manner	stated.
	With Coal		29b. Signature and	title of certifier		11	7.	29c. Licen:		1		29d. Date :				
			30. Name and addre	ess of person who	completed cause of	death (Item	1 23a) (Type, F		720			08	, 20	1	016	
	E.T	3	CHALIT	A C.	ATALLA	+	27 8	poruth G	reent	E St	. BAL	TIMA	re n	no a	21701	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alton Elwood Cassidy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days (Month, Day, Year) Hours Country) 1**X** M 2 □ F 215-52-5826 Director 64 28, 1948 Washington D.C Aug. 10c. City, Town or Location 10d. Inside City Limits 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Bryans Road Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20616 1571 Marshall Hall Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔯 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Company Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Cheseldine Alton Woodrow Cassidy i Health and ∿ item 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1571 Marshall Hall Rd., Bryans Road, Md. 20616 Janice K. Wright Executor t of Heal Baltimoré, 20b. Place of Disposition (Name of cemetery, crematory or other plasept. 4, 2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Waldorf, Maryland Trinity Memorial Gardens 21. Signature of Funeral Service Lice Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. e disease, or complications that caused the death. Do not enter t failure. List only one cause on each line. dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Ves 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit nth, Day,

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lincate	UI DO	Jaiii	T	2. Date of Dea	Reg. No	. Z U 1	-	3. Time o	Dooth 5
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-25.00	Medie Examir		4a. Facility Name (if not institution, give stree			4b. City, To	wn, or L	ocation o	of Death	Вереем		. County of			
			Manor Care			S	ilve	r Sp	ring			Mont	gom	ery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,		9	. Birthpla	ace (State o	or Foreign
	Director		246-03-3515 Usual Residence of Decedent	^{1 2 ဩ F} 93	Yrs.		1			July 28		19 /		kie,	NC
	and show	ا _ة ا	10a. State 10b. County	10c. City	, Town or Loc	ation							10	d. Inside C	ity Limits
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E	Page nent o int: If		1 X Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Fo	emetery, crem rt Linc			y !	9/6/2	.012	Bre	entwoo	d, N	lary1	and
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22	. Name and A	Address	of Facility	у		473	39 Bal	time	ore A	venue
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			23a. Part 1. Enter the deease, or complicate shock, or heart failure. List only one care		n. Do not ente	rthe mode o	of dying,	such as	cardiac or	respiratory arre	est,			Approximat Interval Bet	ween
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oro	w req	plet	Failure to Thrive,							24a. Was a		24b. Wer	e autops	y findings	available
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₹	hysic this of al dire	은	1 Yes 2 X No	1 Inpatient 2 I		t 3 🗆 DOA	Other:	4 🛚 Nu	ırsing Hom	e 5 🗌 Reside	ence 6	Other (S	Specify)		
0	ling P	ate:	1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		. Injury a work?			3d. Describe ho	ow injury	y occurred			
SIO	death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me form etro	M		es 2 🗌		Bf. Location (St	root on	d Number o	r Duml C	Pourto Alumi	201
Division of Vital Records, P.O. Box 687	l or A after Direct	Cer	4 L Homicide determined '	building, etc. (Specify)		ot, lactory, o	illoc			City or Towr			nurai n	oute munn	<i>)ei</i> ,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1 X Certifying Physician	n: To the best of my knowle	edge, death c	ccurred at th	ne time, d	date and	place, and	due to the cau	use(s) a	nd manner a	as stated		
	he Ho in 24 he Fu ipletel	Med	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of examination actitioner: To the best of m	and/or invest y knowledge,	igation, in my death occurr	opinion, ed at the	death oc time, date	curred at the curred at the curred and place	ne time, date an e, an <mark>d</mark> due to th	id place e cause	, and due to e(s) and manr	the caus ner as sta	e(s) and ma ited.	inner stated
-	North North Com		29b. Signature and title of certifier			29c. L	icense n	umber	0	2		te signed (M		ıy, Year)	
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			raman rekna 1041,	M.D., 10010	Darnes	PLOWII	Nuau	, Ga	ar cire.	rangra,	M	20070	,		

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma		artment of Health	and Me	ental Hygier	ne no.201	2	30255
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death		Reg.	No. 2 0 1		
	Physicia		Albert G. Carter			- 1		Day Ye	ear	3. Time of Death 15:35 P ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location			4c. County of		
الهيدة			Fort Washington Hospital		Fort Washi	ngton		Prince	Geo	rge's
	Funeral			94 Yrs.	If Under 1 Year If Under Months Days Hours	Min.	B. Date of Birth (Month, Day, Yea	r)	Country,	
	Director		Usual Residence of Decedent	74 113.		<u> </u>	uly 12, 1	1918 IW	ashi	ngton, DC
	land shov dat	tor	10a. State 10b. County	10c. City, Town or Loc	ation				10d	I. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Charles	White						1 🕅 Yes 2 🗌 No
	th the 3a or t be n		10e. Street and Number		10f. Zip Code			Citizen of Wha	•	
	ath wi	Funeral	4700 Londonberry Lane 11. Marital Status 12. Was Decedent E	verin IIS 13 V	20695 Vas Decedent of Hispanic Ori	igin? (Specif		14. Race -		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Noivorced Armed Forces? 1 Yes 2 K If Yes, Give Year or Dates.	No.	Yes, specify Cuban, Mexican Yes 2 XNo Specify.	n, Puerto Rio	can, etc.)		White, etc	African rican
2-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupation ind of work done during mos	st of working	16b	. Kind of Busin	ess Indus	stry
12	thin 7 ene. than	Completed	Elementary/Seconday (0-12) 2 College (1-4 or 5 years	h) life. DO	NOT use retired) ta Processor			Govern	ment	,
<u>م</u>	Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)	1	18. Moth	ner's Name (/	First, Middle, Maid	en Surname)		
/lan	d be filed Mental Hyg arked oth	욘	Albert G. Carter		M	largar	et L. Bro	own		
Maryland	should be file h and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number					
	and 2 s Health em 27		Albert G. Carter, Jr So 20a. Method of Disposition		Londonberry					
Baltimore,	Page 1 ment of I ant: If it		1 🛂 Burial 2 🗌 Cremation 3 🗍 Removal from State		natory or other place)	Dat		Location - Cit	-	
Ħ.	permit. Page Department Important: Ii any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Mem. Park Name and Address of Facili		15, 2 0 12 wart Fune			
m	Depar Depar Impor any ir		John T- Stewart, 31	1/00E/0	001 Benning R				-	
	Ph _y sician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	I the death. Do not ente e. MEUM MG		cardiac or r	respiratory arrest,		In	pproximate nterval Between onset and Death
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s, P.(requires that the death certific been signed by the attending should be detached for use as	Completed by F	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part	1.	23e. Did tobacc			cause of death?
Division of Vital Records,	v requ	olete					24a. Was an	24b. Wer	e autopsy	/ findings available
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g	ertifica ector, p	Be (25. Was case referred to medical examiner?		26. Place of Dea	ath <i>(Check</i> o				<u> </u>
<u> </u>	Physic this or al dire	은	1 Yes 2 No Hospital: 1 Planpatic 27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatien			e 5 Residence		Specify)	
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isio	or Attending Physician: The law after death. Director: After this certificate has it in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, stre		_	f. Location (Street		r Rural Ro	oute Number,
<u>≥</u>	tal or rs afte al Dir		4 - Hornicide determined building, etc	с. (Specify)	-		City or Town, Sta	ate)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of examiner on the basis of examiner. To the	xamination and/or invest	igation, in my opinion, death o	ccurred at th	e time, date and pla	ace, and due to	the cause	
_	To t Voith Com		29b. Signature and title of certifier		29c. License number	S	29d.	Date signed (N	10nth, Day	/, Year)
	1 Jan		30. Name and address of person who completed cause of de	eath (Item 23a) (Tivne P	rint) rins of an AJH			1-7-	C''	
	0.71		MicHAEL SideRous, M.	1/70/11	ingsofon NH	-101-	ft Wach	Aa r	10	20746
	Sta		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	Ne			0		
	Registra	ar	CEL DESTE TO DEC							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arthur Edward Cohn 2012 September 5:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 21815 O'Toole Dr. Washington Hagerstown If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 214-52-5568 59 Director 1 🛛 M 2 □ F Yrs. July 21,1953 New Jersey Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Washington Hagerstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 U.S.A 21815 O'Toole Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc þ 1 Never Married 2 X Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Communication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marjory Mittleman Julius Cohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celia Kay Cohn (Wife) 21815 O'Toole Dr. Hagerstown,Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10, Smithsburg, Md. Smithsburg Crematory Signature of Euneral Service 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) alcia Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Day Pregnant at time of death Year 9 Unknown g Unknown Part II. Other significant ϕ onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's S State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 September Nancy May Chu 7:25 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Myersville 2 Cedar Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov 23, 1921 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Maryland Director 90 214-16-1838 Usual Residence of Decedent show e filed within 72 hours after death with the Maryland ital Hygiene.
ed other than "natural", or items 23a or 28a-f shoi event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Myersville 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21773 2 Cedar Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black White etc. Yes 2 X No 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event. The I Public School School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Grossnickle Luther Metzger Clara May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Chu / son 8909 Admiral Drive, Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Hagerstown Crematory Sept. 11, 2012 | Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of uneral Servi 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Physician/ Small disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ò Dav Pregnant at time of death 1 Yes ZL 9 Unknown detached je je Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown anemia should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death.

I Director: After the in by the funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

9110

Registrar DHMH 17 Rev 7/2009

State

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

non son 32 Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #21, PER ME G931 9/20/12 TRT Department of Health and Mental Hygiene 2 30258 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 23 Arnold J. Cook 0853 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 62 Taylor Street Salisbury Wicomico Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 212-72-8592 Director 46 1 **X** M 2 □ F 10/28/1965 MD Usual Residence of Deced 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Salisbury 1 Yes 2 X No Wicomico 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 62 Taylor Street 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 → Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Shore-Up, Inc. Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Brown Robert Cook 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is, any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cook/father 402 Trinity Dr., Apt. E, Salisbury MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/1/12 Dover DE 4 Donation 5 Other (Specify) Direct Cremation Bennie Smith Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility PRISCILLA ROUNDS PER DVR 917 W Isabella St., Salisbury MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Morbid Obesity disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypocalcemia, anemia history, history of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of congestive heart failure has death? performe this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital Other: 4 Nursing Home 5 🗷 Residence 6 Nother (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending after death. Director: Af M 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number D59847 M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9714 Healthway Drive, Berlin MD 21811 Atlantic Health Center, parker 32. Red strar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evelvn Davis 2012 Aug. 2:00 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Taneytown Lorien Nursing & Rehab. Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 217-28-6045 1 🗆 M 2 😿 F 80 2/3/1932 MD Usual Residence of Deceder Show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes XX No MD Carrol1 Taneytown 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 131 Carnival Dr. 21787 items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ital Hygiene.

of other than "natural", or iter
event, the Medical Examiner: Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 N Divorced Completed Specify White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Springfield Hospital Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည traumatic Archie Davis Bessie Elizabeth Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Walizer/Daughter 5551 Hidden Water Lane, Frederick, MD 21703 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If i 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury or 4 Dogation 5 Other (Specify) Olive Cemetery 8/31/2012 Mt. Airy, MD 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory 1212 W. Old Liberty Road Sykesville, M 21. Signature of Funeral Service License. any a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Lea resulting in death) Medical Due **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day the P.O. þ 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending work e Funeral Director: Al letely filled in by the fu 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

State

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within 2 To the comple

29b. Signature and

of death (Item 23a) (Type, Print)

istrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Louise Drechsler 2012 August 27 11:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll **Examiner** 344 North Colonial Avenue Westminster If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-14-8581 **Director** 1 🗆 M 2 💢 F 88 Aug 14, 1924 Yrs. Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Westminster Carroll 1 X Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be I Funeral 21157 USA 344 North Colonial Avenue Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Raymond Lee Smith Mary Josephine Cutshall Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 3238 Murray Road, Finksburg, MD 21048 Mary Jo Zentz, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery Westminster, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician 5100 ED disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial Physician/Medical P.O. Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death ed by the a Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4. Unknown Completed plnods Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 🗌 Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 = Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Date filed (Month, Day Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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			Adelphi House 8402 Rambler 5. Social Security Number 6. S	Assisted L	iving	Adel			1	George's
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	land show dat	후	10a. State 10b. County	1	I Oc. City, Town or L	ocation.				10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	D.C.		Washi	ngton				1X Yes 2 ☐ No
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9600	72 hours after death with the Maryland "matural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1		. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black
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Baltimore,	permit. Page 1 Department of Important: If i any injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y)	Quantico	Nat'l. Ce	em. 09/07	7/12	Triangle,	Va.
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~ P	h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		COLON CAN	CER			Onset and Death
and.	Examiner			Due to (or as a co	onsequence of):					
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Box	y the atten	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date of d Month	elivery Day Year
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of Vi	r this certificated director, I	<u>م</u> ا	1 ☐ Yes 2x No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of injury	2 ER/Outpatie		4		nce 6X Other (Spe	
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Division of Vital Records,	rs after de al Directo	Sertificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st specify)	reet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
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			29b. Signature and title of certific	ely, mo		29c. License			ed. Date signed (Moni	
	35m		30. Name and address of person who co			Print)				
	Stat	e_	SONIKA PANDEY, M 31. Date filed (Month, Day, Year)		- 0	STREET N	W, WASHING	GTON, DC	20422/688	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onth Year Medical 20 Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 6 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S Armed Forces? Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian other traumatic event, the Medical Examiner Black, White, etc. ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 4900 64 2 No 1 Yes Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name ne (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ normant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 9 1 Burial 2 Cremation 3 Removal from State cemetery injury 4 Donation 5 Other (Specify) Satanha 21. Signature of Funeral Service Licensee 100054/VZ nsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1. Enter th Approximate shock, or he a fail Immediate Cause (Final failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ģ Day Pregnant at time of death signed by the at the detached for g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy After this certificate 1 Yes 2 No Yes Division of Vital funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 IDCA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 🗀 Pending ithin 24 hours after death.

o the Funeral Director After
ompletely filled in by the fun 1 Natural iniury work? 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h. To the Fun Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitione dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 5.4 who completed cause of death (Item 23a) (Type, 0 State Registrar

DHMH 17 Rev 06-2011

12-06345 Francis Patrick I	Digi		pe or Print i								ible.		
		1- For State Registrar	J	•	ertificate of		uu	morna.	, g		.No. 20	11:	2 3028
Physicia	an/	1. Decedent's Name (First, Midd		-					2. Date Month	of Death	Day Year		3. Time of Death
Medical Exami	ner	Francis Patri 4a. Facility Name (if not institution				th City Tay			Augu	st 22,	2012		1942 hrs
·		Highway 50 and Linky		umber)	ľ	Linkwoo		ocation of De	eatn		4c. County of Dorchest		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	1 Year	If Under 24	Hrs. 8. Date	of Birth	(MM/DD/YYYY)	9. Birth	nplace (State or
Director		212-68-5303	1X M 2 F	51	Yrs.	Months	Days	Hours 1	Min. Ju	1y 3	30,1961	Foreigr Cou	n Intry) Marylan
<u> </u>		Usual Residence of Decedent 10a. State 10b. County		140- 03	, Town or Locati								
1 10w any			Arundel	1 1									10d. Inside City Limits 1 Yes 2 X No
nylanc In-f sh	ctor	10e. Street and Number	Arunder		dgewate:	10f. Zip Co	ode	-		100	. Citizen of Wha	ot Count	- 11
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	850 Holly Aven	iue			210					USA		
1 with ms 23 be no	era	11. Marital Status	12. Was Dec	cedent Ever in U		Decedent of	of Hispa	anic Origin?	(Specify Yes	or No-	14. Race -		an Indian, Black,
r death	Funeral	1 Never Married 2 X M	1 Yes	2 X No		10			erto Rican, et	C.)	White,		
5-0036 lied within 72 hours after Hygiene. to ther than "natural", the Medical Examiner.	þ	3 Widowed 4 Div	orced If Yes, Give Yea or Dates:		16a. Decedent	Yes 2.	,		of work days	la	Specify:		√hite
2 hou	eted	Elementary/Secondary (0-12)	College (1					O NOT use			6b. Kind of Bus	ness/In	dustry
036 rithin and rate of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o	Comple	11th			Owner						Fire Pr	oteo	ction
Hygin Hygin	ပ္ပ	17. Father's Name (First, Middle,		C:==1==	-		18				iden Surname)	1	-
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	19a. Informant's Name/Relations	Joseph Di	.G11 010III		Address (Stroot a				Coste1	_	7in Cada)
		Debbie Jo DiGi		ife	850 I	Holly	Ave	nue, I	Edgewai	ter,	Maryla:	nd 2	21037
Baltimore, MD vernit. Pages 1 and 2 sho Department of Health and impartant: If item 27 is njury nr other fraumati		20a. Method of Disposition		20b.	Place of Disposit crematory or other		of ceme	tery,	Date	2	20c. Location - C	City or T	own, State
Pages Pages of the total		1 Burial 2 X Cremation 4 Donation 5 Other Sp		om State Ka.	las Crem	atory		8	/27/12	: 1	Edgewat	er,	Maryland
Salti armit. epartin ipurta		21. Signature of Funeral Service											al Home
		23å. Part I. Enter the disease, or	complications that o	a condition death	297	73 So1	omo	ns Isl	Land Ro	d. E	dgewate	r, M	ID 21037
Physician /Medical		failure. List only one cause	on each line.		. Do not enter th	e mode or a	ying, su	ich as cardia	c or respirato	ory arrest	, snock, or near	·	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inju	consequence o	of):								
	_	Sequentially list conditions,	b.										
	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	r):								
ed nsit	Examiner	events resulting in death) Last	,	consequence o	f):								
executed an and al - trans	= 1	UNPENDED	dAMENDED									\dashv	
60, ate be hysicii e buri	Med	IF FEMALE:		outcome of preg	nancv						23d. Date of de	elivery	
687 ertific ding p	ian/	23b. Was decedent pregnant in the past 12 months?	e 1 Live b	irth	2 Feta	ıl death	3	Ectopic preg	nancy		Month	Da	y Year
30x death death of	Physician/Medica	1 Yes 2 No 9 Unk		ant at time of de wn	5 Othe	er (Specify)				- 1	8		
Division of Vital Records, P.O. Box 68760, rsi mr Attending Physician: The law requires that the death certificate b rs after death. 12 Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the but		Part II. Other significant conditi	ons contributing to	death but not re	esulting in the un	derlying cau	ise give	en in Part I.	23e.	Did toba	cco use contribu	te to th	e cause of death?
S, D uires th	ed by					_			_ 1	Yes	2 ✓ No 3	Probal	bly 4 Unknown
ord aw requas been	plet								_	Was an autopsy	prio	or to cor	psy findings available npletion of cause of
Rec The la	Completed								1 🗸	performe Yes 2		ath? ✓ Yes	2 No
ital iician: s certif irector,	8	25. Was case referred to medical examiner?	Hospital:		FR(0) 1' 1			Death (Chec			[3]	27	
of V g Phys fter thi	유	1 Yes 2 No 27. Manner of Death	28a. Date o	npatient 2	ER/Outpatient 28b. Time of Inj		_	at Work?	sing Home		sidence 6 🗸		Scene
On cending sath.	흷	1 Natural 5 Pendi		Day.Year) 2012	1902 hrs	1	Yes	2 ✓ No					in collision with
ViSi nr Att fter de jin by :	<u> </u>		not be 28e. Place	of Injury - At ho	ome, farm, street,	factory, offi	ice build	ding, etc.	28f. Locat	ion (Stre	et and Number	or Rura	Route Number, City
Di spital s tours a filled	Certification:	4 Homicide determ	mined (Specify)	Major Road	d / Highway				Highway	wn, State 50 and	e) Linkwood Driv	e, Link	wood, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital ar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>8</u>	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best niner:On the basis o	of my knowledg	ge, death occurre	ed at the time	e, date a	and place, a	nd due to the	cause(s) and manner as	stated	Causeds)
To t with To t	Medical	29b. Signature and title of certifier	and manner st	ated		29c Lic			at the time,		9d. Date signed		
	20	Pot . An	. D	000 1			C.M.E				ugust 23, 2		,,,,,
1	+	30. Name and address of person	who completed cause	e of death (Item	23a)						-		
410		Patricia Aronica-Pollak		nt Medical E		00 W. Ba	altimoi	re Street,	Baltimore	, MD 2	21223		
Sta Registr	ite ar	31. Date filed (Month, Day, Year) AUG 28	2012 32. R	gistrar's Signatu	d. Sa	N.							
		110011											

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30264 StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2012 7:00 A M Nellie F. Dyson August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 31, Hours 98 Roanoke, VA Director 578-32-8021 1914 1 □ M 2 🎛 F Yrs. Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral USA 333 Russell Avenue 20877 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decesor... Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use refire. Privision Chief, 16b. Kind of Business/Industry (Specify only highest grade completed) Department of and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the of Finance & Accounting the Army 5+ Be traumatic event, should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Effie B. Abshire Ellis Edward Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health au Important: If item 27 is any injury or other trau once. Suzanne Fanning - Granddaughter 2514 Kitmorr Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 9/1/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 4739 Baltimore Ave. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Ofter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death
3 days shock, or heart failure. List only one cause on each line Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner years Debility Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Examine Due to (or as a consequence of) Osteo arthritis years Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dementia 1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2.9 performe 2 🗌 No Yes 2X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 🗵 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending 1 🗌 Yes Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie

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State

Registrar

TA

M

911 Russell Ave, Gaithersburg, MD 20879

ess of person who completed cause of death (Item 23a) (Type, Print)

John R. Melnick

7

31. Date filed (Month, Day, Year)

AUG 2

D19294

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / De	partment of Health and N	lental Hygie	ene 2012	30265
		_	Registrar	ertificate of Death	Reg	J. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Marianne Luise Duren		2. Date of Death Month Aug 21,	2012	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Aug 21,	4c. County of Death	7:40 P M
	Examili	ei	Holy Cross Hospital	Silver Spring		Montgon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	pplace (State or Foreign
	Director		213-82-0920 1□M2⊠F 85 Yrs	Months Days Hours Min.	(Month, Day, Ye		rmany
	nd how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	100 13,		10d. Inside City Limits
	larylar 3a-f s iffied	Director	MD Prince George's Bo	vie			1 ☐ Yes 2X No
	or 28	ᄒ	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	s 23a ust b	Funeral	12501 Lanham Severn Road	20720		USA	
	death item	큔	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	after al", or xami	d b	Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 🖾 No Specify:	101001.00-7	Specify: US	
9	nours natura ical E	Completed by	15. Decedent's Education 16a, De	cedent's Usual Occupation	16	6b. Kind of Business/Ir	ndistry
215	in 72 e. nan "r Med	틽	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5+)	ve kind of work done during most of work . DO NOT use retired)	ing	D. Kind of Edsiriess/ii	loosily
7	ygien ygien her th	ادہ ا	12 H	ousewife		Own Hon	ie
and	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "hatocal Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	면 B	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Mai	iden Surname)	(a
چّ	d Mer mark matic		Eugene Koch 19a. Informant's Name/Relationship (Type, Print) 19b. M	Maria			(unavailable)
Z	2 shouth and 127 is 17 trau		102.10	ailing Address <i>(Street and Number or Rura</i>)1 Lanham Severn Rd			Code)
ē,	1 and of Hea item other		20a. Method of Disposition 20b. Place of Di	sposition (Name of		C. Location - City or T	own, State
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of the supportant: If ite any injury or of once.		The bond 242 of mation of a fiction of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the f	rematory or other place) itan Crematory 8/2	4/12 A	lexandria	. VA
alti	armit. spartr sports ny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		739 Baltim	
<u> </u>	90 E # 9			Gasch's Funeral Hom			, MD 20781
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
-	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death) Sepsis with Sho	ck			Onset and Death
	Examiner		Due to (or as a consequence of): Urinary tract i	afaction			
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	HECCION			
	uted d ansit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	ian ar urial-tı	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
90	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	gic	d				-
P.O. Box 687	requires that the death certifics been signed by the attending p should be detached for use as 's		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				
ŏ	atten aften i for u	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	very Day Year
B	the de by the achec	hysi	g Unknown				
9.	that gned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ds,	quires en sig ould b	ted	Severe cardiomyopathy		1 🗆 Yes	2 🖾 No 3 🗆 Pro	bably 4 🗌 Unknown
ç	a law re has be ge 2 sh	nple	Acute kidney injury		24a. Was an autopsy	prior to co	psy findings available empletion of cause of
Re	:The la cate ha		Alzheimers dementia		performed	d? death? S No 1 Ses	2 🗆 No
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	(only one)		
ž V	Phys rthis aral di	<u>ا</u>	1 ☐ Yes 2 ☒ No Prospital 1 ☒ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Tim	tient 3 □ DCA 4 □ Nursing Ho	me 5 Residence 28d. Describe how i	e 6 Other (Specify	0
Division of Vital Records,	or Attending after death, Director: After in by the fune	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injur	work? M 1 Yes 2 No	zod. Describe flow i	injury occurred	
isic	er des	ertif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		et and Number or Rura	l Route Number,
<u>S</u>	ital or raf Dir lled in	S S		illa and a second	City or Town, S		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dea	estigation, in my opinion, death occurred at	the time date and n	lace and due to the ca	use(s) and manner stated
	To the within 2 To the comple	Ž	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	ge, death occurred at the time, date and pla 29c. License number	ace, and due to the ca	ause(s) and manner as . Date signed (Month,	stated.
	≓ ≯ F ŏ			D52503	290.	8/22/12	bay, reary
	13 Im		30. Name and address of person was completed cause of death (Item 23a) (Typ	e, Print)			
	g1		Shailesh Sheth 1500 Forest Glen	Rd., Silver Spring	, MD 2091	0	
	Stat	C	31. Date filed (Month, Day, Year), 2012 32. Registrar's Signature	racks			
	Registra	ır					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year 2:20 Sept а м Betty Jane ECKSTINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport <u>Williamsport Nursing Home</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** May 8 1933 1 🗆 M 2 💢 F 79 Maryland Director 218-30-9329 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No 21740 Maryland Washington 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21740 388 Key Circle death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 X Married þ 1 Yes 2 X No be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is mo-ပ Mary Pearl Harsh Walter Perry Beckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 388 Key Circle, Hagerstown, Maryland 21740 <u> John E. Eckstine - Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/14/2012 Williamsport, Maryland Greenlawn Mem. Park of Funeral Service Li 22. Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a conseque if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transit and that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No has this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🔀 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature a 1ahmos

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, #31 per FCHD TM 9/5/12 amend #1 per MD #18 per FH FCHD TM 9/13/12

State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Mary Ellen Eaton 1516 Mary Econ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of MD Baltimore, MD 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 212-38-9678 Director 1 M 2 P 73 2/11/1939 Maryland Usual Residence of Deceden 28a-f shov Oa. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States of America 913 Pine Avenue death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 Yes 2 XNo If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify "natural", Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Dining Room Manager Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. Lewis D. Lenhart Mary L. Howse Mary L. Hawse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Bell / Friend 913 Pine Avenue, Frederick, Maryland 21701 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 5, 1 🗌 Burial 2 🗷 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Smithsburg Crematory Smithsburg, Maryland Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition acute myocardial Wowon Medical resulting in death) Examiner Proprietory failure Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ed by the a 9 Unknown signed by 1 d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed' within 24 hours affer death.

To the Funeral Di ector: After this certificate I completely filled in by the funeral director, pag 2 No Yes 2 🛂 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 Yes 2 No 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital of Attending 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier YCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 9/02/12 102292 30. Name and naddress of person who completed cause of death (Item 23a) (Type, Print) 0 22 S. Greene St. Sactimore, U.P. tieng-Ramos, mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

		Plea	ase Type or Pr				k. Ensure A lealth and N	_		egible.	
	-	For State Registrar		iai yiai k		tificate of L			Reg. No.	2012	3026
Physician Medica		1. Decedent's Name (First, Middle JOSEPH DOM	e, Last) ENIC FEDEI	LI				2. Date of De Septem		20 ′1 °2	3. Time of Death 8:00 AM
Examine		4a. Facility Name (if not institution 9412 Union Pla					Location of Death	ge		nty of Death	7
Funeral Director		5. Social Security Number 207–36–8767	6. Sex 1 [X] M 2 □ F	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir July 2	th 3 Year 947		olace (State or Foreign
yland -f show ed at	- 1	Usual Residence of Decedent 10a. State 10b. County Maryland Montg			Town or Loc	ation Village				11	0d. Inside City Limits
vith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 9412 Union Pla	ce			10f. Zip Code	20886		-	of What Coun	
ter o	প্র	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🖾 Divorced	1 100 1 1	Ever in U.S.		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🗓 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. F Spec	Race - America Black, White, e	
ithin 72 hou ene. than "natu he Medical	Completed		nt's Education est grade completed) College (1-4 or	5+)	(Give k	ent's Usual Occup ind of work done o NOT use retired) Presiden	luring most of work	ing		f Business Ind	
l be filed widental Hyginrked other	ωŀ	17. Father's Name (First, Middle, L Authur Domeni	Last)				18. Mother's Name Grace Sc		Maiden Surna	ame)	
nd 2 should ealth and N m 27 is ma her trauma		19a. Informant's Name/Relations Mark Joseph Fe					and Number or Rura l Road Ga:				
: Page 1 ar tment of H tant: If itel jury or oth		20a. Method of Disposition 1 🖔 Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$	3 🛚 Removal from State Specify)	ce	metery, crem lvary	sition (Name of atory or other plac Cemetery	e) Sept 20	11,	Altoo	na, PA	
permit Depar Impor any in once.		21. Signature of Funeral Servige L	Licensee (MC)1116)			ss of Facility DeV er Park I				20877
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each line. aa. Due to (or as	1e. 3 C V	0	r the mode of dying	g, such as cardiac c	r respiratory an	rest,		Approximate Interval Between Onset and Death
izi e	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the by		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant g ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of delive Month	ry Day Year
uires that t in signed b uld be deta	≥	Part II. Other significant condition	ons contributing to death	but not resu	lting in the ur	nderlying cause giv	en in Part I.				e cause of death?
sician: The law req	Completed							24a. Was autop perfo 1 Yes		b. Were autop prior to con death? 1 \(\sum \) Yes	sy findings available npletion of cause of 2 No
lysician is certifi director	lo pe	25. Was case referred to medical examiner? 1 X Yes 2 \(\subseteq \) No	Hospital:	ient 2 🗆 E	R/Outpatient	Othe	ace of Death (Checker: 4 Nursing Ho	1.	dence 6□C	other (Specify)	
ending Ph sath. or: After th he funeral	Certificate:	27. Manner of Death Natural 5 Pendir Accident Investig	gation	ury 2 ay, Year)	28b. Time of injury	28c. Injury work' M 1 □	at	28d. Describe h			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of Injuried building, et	c. (Specify)		et, factory, office		28f. Location (S City or Tow	n, State)		
he Hosp in 24 hou he Fune ppleted fi	Medical	(Check 2, Medical E	Physician: To the best or xaminer: On the basis of Nurse Practioner: To the	examination	and/or investig	gation, in my opinio	n, death occurred at	the time, date a	nd place, and	due to the caus	se(s) and manner stated.
20 sith of 20		29b. Signature and title of certifier	00 1	- mo	OME	29c. License		.	29d. Date sign		Pay, Year) 2012
7		30. Name and address of person				int) 524	9428 Magni	-05 P O	7	4~	./
State Registrar		31. Date filed (Month, Day, Year)	6 ms 12	ar's Signatu	re ARA	c1 ()	er spr	153	IDU .	3,070	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 31, 2012 ear Physician/ 09:54 amM Penny Ann Fuchs Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
Montgomery 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 228-19-9428 50 June 07, 1962 TEXAS 1 🗆 M 2 🗗 **Director** Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No MD Silver Spring, Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20905 USA 105 Farmgate Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Black, White, White Armed Force 1 Never Married 2 Married Yes 2 XNo 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 If Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) Georgeanne Wick 17. Father's Name (First, Middle, Last) ၉ Michael Bender ^{19a}, Informant's Name/Relationship (*Type, Print*) Michael S. Fuchs/Husband 196 Mailing Address (Street and Number of Rural Route Number City of Toyan State Zin Gode)
105 Farmgate Lane Silver Spring, MD State Zin Gode) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept 01, 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Department or Important: If any injury or ō Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Francis J. Collins Emeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Metabolic Acidosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hyperkalemia Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hyponutremia Hospital or Attending Physician: The law requires that the death certificate be executed transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician page 2 should be detached for use as the buria Physician/Medical Advanced Stage IV Breast Cancer Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 XNo 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 1 Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 1X Inpatient 2 ER/Outpatient 3 DOA ၉ 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural injury work?
1 Yes 2 No 5 Pending within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I 3 [only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D66372 August 31, 2012 YM OWICE 3

DHMH 17 Rev 06-2011

Registrar

State

16

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Majid Rahmanian Shahri, MD

SEP 0 4 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Irwin Gifford State of Maryland / Department of Health and Mental Hygiene 2012 30270 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day Year September 14, 2012 Robert Irwin Gifford 1905 hrs 'adical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington 9824 Old Fort Road 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours Director 1 XM 2 F CountryVirginia 217-60-6261 Yrs 58 May 31 1954 Usual Residence of Decedent 10d. Inside City Limits ij 10c. City, Town or Location 10b. County 1 Yes 2 No 28a-f show Maryland Prince George Fort Washington Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If them 27 is marked other than "natural", or items 23a nr 28a-f sho rother traumatic event, the Medical Examiner must be notified at one. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9824 Old Fort Road 20744 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: White ğ r Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Master Mechanic U.S. Government 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert A. Gifford Kathleen E. Irwin 19a. Informant's Name/Relationship (Type, Print) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela N. Young Daughter 6711 Tower Drive, Alexandria, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Sept. 1 Burial 2 X Cremation 3 Removal from State 2012 Alexandria, Virginia Metropolitan Funeral Service Donation 5 Other Specify ō 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Fur M00668 4270 Hawthorne Rd., Indian Head, 20640 lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 23a. Part I. Enter th one cause on each line Between Onset and Death Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and tran Physician/Medical AMENDED 23a, pt. II, 27, per me, g931 9-25-12 sm the attending physician a X UNPENDED Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus: Obesity: Chronic Alcohol Abuse Completed peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has } death? performed' Yes 2 No : certificate 1 🗸 Yes 2 No the Huspital o Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No hours af er death. th. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a To the Funeral L 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 15, 2012 abell 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (MoSEP) Registrar's Signatur State 1°8 2012

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wilbur Herman GRAHE 7:51 am 9012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tager Dashington enter UYSING raven wood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace State or Foreign
Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 F Months Days 215-05-9111 93 July 25, Director 1919 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hyglend. In the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Companiest of the Compani Director Maryland Washington 1X Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1158 Luther Drive Apt 48 21740-7695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) office manager 12 trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Grahe Annie Woody 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona E. Delauter - daughter 135 Drake Avenue, Falling Waters, West Virginia 25419 20b. Place of Disposition (Name of ceretery, crematory or other place)

Cedar Lawn Memorial September Hagerstown, Maryland

Park Funeral Home Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Solut (R. Cark 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? as s autopsy page certificate l performed 20X No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours after death. 5 Pending investigation within 24 hours after user...
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) shahid Mahmod 580C Northern 11) 31. Date filed (Month, Day, 32. Registrar's Signature State Year) 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09 12:59 p^M Gloria Cecillia Gill 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington 19636 Spring Creek Road 7. Age (In yrs. last birthday) er 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 135-16-6796 1 M 2 X F 89 05/19/1923 New Jersey Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Numbe ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 19636 Spring Creek Road 21742 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes Yes Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Retail 12 Retail Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Teresina Carmilani Camillo Carmilani other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandy M. Shuster / Daughter 13571 Donnybrook Drive Hagerstown, MD 21742 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 09/11/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rest Haven Cemetery Funeral Salvic 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, n⊮al Betweer Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2**X** No the 9 Unknown 9 Unknown Division of Vital Records, P.O. by **significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be B 26. Place of Death (Check only one) Hospital 2 X No Other: 1 \sum Yes |으 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 24 hours after death. e Funeral Director: After this oletely filled in by the funeral of 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at I or Attending P 1 Natural 2 Accider injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

within 2 To the I

(Check

only one 29b. Signatur

> Mame and address STE

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

se number

29d. Date signed (Month, Day, Year,

Cerylaying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. Lice

12-06755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Greene		State of Maryland / Departmen 1- For State Certificate Certificate	it of Health and Mental H e of Death	ygiene Reg. N	201	2 302
Physici		1. Decedent's Name (First, Middle,Last)	~~	Date of Death Month Date	v Year	3. Time of Death
Medical Exami ⊶्	ner	Robert Wayne Greene 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	September 6,	2012 4c. County of Death	2146 hrs
		4704 Airport Road	Salisbury		Wicomico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219-62-7881 57	y) If Under 1 Year If Under 24Hrs Months Days Hours Min		M/DD/YYYY) 9. Birt 1955 Cou	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
≱ .	Ŀ	Maryland Wicomico Salisbu	ry			1 Yes 2 No
Maryland 28a-f show d at once,	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Coun	try?
MD 21215-0036 1.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 1.7 is marked other than "natural", or items 23s or 28s-f shoumstie event, the Medical Examiner must be notified at once.		4704 Airport Road	21804		U.S.	
eath w	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
after d al", or	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: White	е
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of v ng most of working life. DO NOT use reti		b. Kind of Business/Ir	ndustry
D36 thin 72 ne.	Completed	11 Me	chanical Installer		Construct	ion
5-00 iled wit Hygien I other			18.Mother's Name	(First, Middle, Maide	en Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Clarence Greene 19a. Informant's Name/Relationship (Type, Print) 19b. M.	In Norma Address Street and Number or F	Price Rural Route Number.	City or Town, State.	Zip Code)
Baltimore, MD 21215. permit. Pages I and 2 should be flice Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, th			27 Sherree Lane, P			
s l and of Heal of Heal			isposition (Name of cemetery, or other place)	Date 200	c. Location - City or 1	Fown, State
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: Salis	bury Crematory 09/		Salisbury,	Md.
Bal permii Depar Impo		21 Sgnature of Funeral Service Licensee M00295	22. Name and Address of Facility H: 11673 Somerset Ave	inman Fune enue, Prir		Md.
Physician	\exists	Ja. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	*	-		Approximate Interval Between Onset and
/Medical Examiner	9	Immediate Cause (Final disease a. Oxycodone Intoxica	tion			Death
, A		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of):		-		
d d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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60, ate be ex oby sician be burial	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	,,,		3d. Date of delivery	
Sox 6876 leath certificate e attending phy for use as the b	ल	23b, Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna	ncy	Month Da	ay Year
Box 6876 e death certificate the attending phy ed for use as the !	Physici	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
F, P.O. ires that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.		o use contribute to the	he cause of death?
ords, F v requires s been sign should be				24a. Was an		opsy findings available
e law re has b	Completed			autopsy performed	? death?	ompletion of cause of
Division of Vital Records, rate a Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the but the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Be Co	25. Was case referred to medical	26.Place of Death (Check of		No 1 ✓ Yes	2 No
Vit;	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		g Home 5 Resid		Scene
n of ading Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year) 1 Natural 5 Pending 5 0 6 12	1 Vas 2 V Na	28d. Describe how in unknown	ijury occurred	
Division pital or Atten ours after death teral Director: filled in by the	ertification:	2 Accident Investigation fd 9-6-12 fd 21 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm,	1:30 рщ			al Route Number, City
Divingularian of cours affilled i	Cert	4 Homicide determined (Specify) Single Far	mily Home	or Town, State)	4704 Airpo MD.	rt Rd.
Division of Vital Records, P.O. Box 68760, vittin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inves and manner stated.				
H % H S	ž	29b. Signature and title of certifier	29c. License number		Date signed (Mont	
		a de Hallan	O.C.M.E.	Se	eptember 7, 201	۷
		30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 V	V. Baltimore Street, Baltimore,	MD 21223		
Si Regis	ate trar	31. Date filed (Month, Day, Year) 32, Registrar's Signature	and i			
DHMH 17 Rev 1/2		OCME ORIGI	NAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Guy Kathryn September 9:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Absolute Assisted Living Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Months **Director** 578-20-6250 90 1 M 2 X F 11/18/1921 Kentucky Usual Residence of Decedent 28a-f show death with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4911 Brooks Road 20853 United States items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: White "natural", Specify: Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Nick Faller Edith Kernev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trat Sue Guy (daughter-in-law) 17605 Olney Lane, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State September Fairfax Mem. Park 4 Donation 5 Other (Specify) 6,2012 Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mª William DeVol Funeral Home, Gaithersburg, Deer Park Drive, MO1202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Stroke Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, reading to infine date cause. Enter Underlying Examine Due to (of as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician buria Physician/Medical Division of Vital Records, P.O. Box 68760 the t as nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ó in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Poor Oral Intake 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available Decline in Functional Status prior to completion of cause of death? page perform Depression certificate 2 No Yes 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 X Other (Specify) Living Hospital Other: 2 **X** No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 1 X Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A

Completely filled in by the f Accident Investigation Suicide

State Registrar

Medical

3 Suicide 4 Homicide

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

6 Could not be

SEP 06 2012

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D46245

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office

Sonal Patel, MD, 10810 Connecticut Avenue, Kensington, MD 20895

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) September 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:20a M 30, 2012 Virginia Muller Granger August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13428 Fairland Park Drive Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Min. (Month, Day, Year ug . 4 , 1 Months Hours New York 577-46-9252 81 Director โ′931 Aug. Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Bethesda Maryland Montgomery 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10007 Parkwood Drive 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Secretary Marriott Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Muller Virginia Brockner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13428 Fairland Park Dr. Silver Spring, MD 20904 Lawrence G. Granger (Son) Date 5, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Kenisco Cemetery Valhalla, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Plasma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Month ate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Son's Residence Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) 1 🗌 Yes 2 X No ြုပ ER/Outpatient 3 DOA 1 Inpatient 2 : After thi funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar

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29b. Signature and title of certifie

SH 31. Date filed (Month, Day, Year) **SEP 0 5** 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2. Registrar's Signature

7090

4940 EASTERN AVE

30,2012

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ Irene Hart Grady August 31, 1:24 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min 035-22-6715 78 Director 1 🗆 M 2 🔼 F March 10, 1934 Rhode Island Usual Residence of Deceden show "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19104 St. Johnsbury Lane 20876 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Specify: White Baltimore, Maryland 21215-0036 1 . Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Reading Specialist Education 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ Hector Hart Mabel Hollings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is
any injury or other trau Kathleen Falcinelli/Daughter 1200 Harding Lane, Silver Spring, MD 20905 20a. Method of Disposition

1 K Burial 2 C Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
All Souls Cemetery Sept. 5 2012 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical pletely filled in by the funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ly August 31st in the past 12 months? Dav Year Pregnant at time of death 2 XNo 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 😾 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 XNo မ 1 🔲 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident 3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number MD D67986 August 31, 2012 of address of person who completed cause of death (Item 23a) (Type, Print)
Yuneng Li, MD 8600 Old Georgetown Road, Bethesda, MD 20814 30. Name

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 4 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 30277 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 24, 2012 Ellen McKenny Gallagher 12:25 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 472-16-0343 **Director** 1 □ M 2 🏻 F 91 02/02/1921 Minnesota Usual Residence of Deced 28a-f show 10b. County at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Washington DC 1 ¥ Yes 2 □ No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a 4445 South Dakota Avenue NE 20017 United States items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced Completed Year or Dates Medical 16b. Kind of Business/Industry
Surgeon General's Office 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 72 lith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Jackman Edward McKenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s Department of Health a Important: If item 27 is any injury or other tra Edna Wagner / Sister 4445 South Dakota Avenue NE Washington, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/2972012 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility Joseph Gawler's Sons LLC. Signature of Funeral Service 5130 Wisconsin Ave. NW Washington, DC 20016 CC0379 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Perforated Duodenum disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Choledocholithiasis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) B Exami cafe be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🌁 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No Yes 2 X No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕱 No Hospital 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check counted at the time, date and place, and due to Certifying Nurse Practitioners To the best of my knowled, 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 August 24, 2012 D26259 30. Hame and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

Wisconsin Avenue Bethesda, MD 20814

8218

Ava Kaufman, M.D.

SEP 04

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla				Mental Hyo	giene	1 0	00070
		_	State Registrar	Cer	tificate of L	Death		Reg. No. ZU	12	30278
Е	Physicia Medic	_	1. Decedent's Name (First, Middle, Last) KENNETH LEON HOLLAN	1D			2. Date of Dea Month		ear 12	3. Time of Death 5:10 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o		ath	4c. County of		
Marine 1	-		212 Long Avenue 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Salisb If Under 1 Year		s. 8. Date of Birt	Wicon		lace (State or Foreign
	Funeral Director		220-24-1648 1 m 2 D F 83	Yrs.	Months Days	Hours Mi		(, Year)	Count	
	and show at	o	Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Lo	cation				1(Od. Inside City Limits
	Maryla 28a-f otified	Director	Maryland Wicomico	Salisbu	ry				\perp	1 X Yes 2 No
	with the 23a or ust be n	Funeral D	10e. Street and Number 212 Long Avenue		10f. Zip Code 218	04		10g. Citizen of What USA	at Count	try?
936	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	β	11. Marital Status 1 □ Never Married 2 🛛 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in UArmed Forces? 1 □ Yes 2 🔄 No If Yes, Give Year or Dates.	ŀ	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pue		14. Race - Black, Specify:	America White, e	etc.
Baltimore, Maryland 21215-0036	within 72 hours giene, ler than "natur i, the Medical i	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I life. De	dent's Usual Occup kind of work done o O NOT use retired)	during most of w	orking	16b. Kind of Busin		dustry
d 2	led wi Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)	Nec	on Tube B		ame (First, Middle,	Signage Maiden Surname)	2	
ylan	ld be filed Mental Hy Iarked oth atic event	2	Nicholas Henderson Holland			Cathe	rine Loui	se Shiple	≥ y	
Mar	12 shoulalth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Nellie L. Holland/Wife	1				City or Town, State MD 2180		ode)
imore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		1 Burial 2 X Cremation 3 Bemoval from State		sition (Name of natory or other place of Delmary	a 9/4	Date /2012	20c. Location - Ci		
Balti	permit. Departr Importa any injt		21. Signitury of Funeral Service Ligen		Name and Addre	ss of Facility eral Ho cean Ci	me, P. O. ty Road,	Box 317 Salisbury	1 y, M	D 21802
	Physician/		25a. Port 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		er the mode of dyir					Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a conse			, , , , , , ,				, , , , , , , , , , , , , , , , , , , ,
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P.O. Box 687	ath certific attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fe Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date		pry Day Year
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Division of Vital Records,	I Physician: The law req rrthis certificate has bee eral director, page 2 sho	Completed	resal insufficience	3			24a. Was autop perfo 1 \sum Yes	prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior prior	or to con ath?	osy findings available impletion of cause of 2 In No
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o uc	nding ath. r: After re fune	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	worl	yat k? Yes 2 □ No	Zod. Describe II	ow injury occurred		
ivisio	after des Director In by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tow	Street and Number (n, State)	or Rural	Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examinat only one) 3 Certifying Nurse Practitioner: To the best of my knot only one)	tion and/or inves	tigation, in my opini	on, death occurre	d at the time, date a	nd place, and due to	the cau	ise(s) and manner stated.
	Vithi Vothi Comp		29b. Signature and title of certifier	ho	29c. Licens	e number	. 1	29d. Date signed (I		2012_
0	Bo		30. Name and address of person who completed cause of death (It	em 23a) (Type, F						21864
	14	10	RODNEY A. WENRICH, P.D. 134 31. Date filed (Month, Day, Year) 32. Registrar's Sign		VISION	ST. S	BALISBU	RY MD		
	Sta Registr		SED 0 6 2012	1 1	all					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kenneth Scott Hughes Sr. 7:58^{A M} 2012 9 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Director 216-38-8264 1 XM 2 | F 3-24-1941 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Dorchester MD Madison 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1066 Taylors Island Road 21648 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?

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If Ves, Give 1963 1 ☐ Never Married 2 🔀 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. nit. Page 1 and 2 should be filed within a second partment of Health and Mental Hygiene.
Portant: If item 27 is marked other than "natural" Specify: "natural", 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Recreational <u>Charter Boat</u> Captain <u>Marine</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kenneth Sherwood Hughes Edith Keyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1066 Taylors Island Rd. Madison, Md 21648 Janice Elaine Hughes/wife Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o 1 🗆 Burial 2 🙀 Cremation 3 🗆 Removal from State 9-7-2012 Cambridge, Md 4 Donation 5 Other (Specify) Mid Shore Center . Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Newcomb&Collins FH.Cambridge, Md 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Hemorrance Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed page 2 should need 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b autopsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ျ completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🖵 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANWY ST CAMPRIDGE MD BYRN 503

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

12-06408								ble ink. I					gible			
Craig Westley H			Sta	ate o	f Marylar			ent of Hea		id Ment	al Hyg	giene		20) 2	3028
		1- For State Registrar					ertific	ate of Dea	ath				eg. No.			
Physicia Medical Exami		1. Decedent's Nam	ne (First, Middle ig Wes		7 Hugh	es,	Jr.					Date of Dea Month August 25	Day	Year		3. Time of Death 0159 hrs
Ì		4a. Facility Name (-				1 1	, Town, or dalk	r Location of			4c.	County of altimore		ty
Funeral		5. Social Security I	Number	6. Sex	7.	Age (In yr	s. last birt	hday) If Un	ider 1 Yea	ar If Under	24Hrs.	8. Date of Bir	th(MM/I			place (State or
Director		219-06-4		1× N	1 2 F	2	27	Yrs. Mon	ths Day	rs Hours	Min.	Nov 7	, 19	984	Foreign Cour	ntry) MD
ny	ŀ	Usual Residence of 10a. State	10b. County			10c. C	ity, Town	or Location						-	T	I0d. Inside City Limits
nd show a	٦	MD	Balt	imoı	re		Dun	dalk								1 Yes 2 No
Baltimore, MD 21215-0036 Peparit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu. 7864 St	_{imber} t. Greg	ory	Drive			10f. Z	ip Code	21222		1	_	en of Wha JSA	at Count	y?
with t	eral	11. Marital Status			2. Was Deced		ı U.S.	13. Was Dece		spanic Origi n, Mexican,)-	14. Race - White,		an Indian, Black,
er death , or ite	Funeral	1 Never Marri	ied 2 🗶 Ma		Yes, Give Year	2 X No	0		_	specify:	1 40110 11	odii, oto./		Specify:		e.
irs aft ural"	2	15. Decedent's E		0	r Dates:	completed)) 16a.	Decedent's Usua	74-		ind of wo	k done		ind of Bus		
2 hou	ec.	Elementary/Sec		Ť	College (1-4		\exists	during most of w	orking life	e. DO NOT u	use retired	d)	Adv	ance	Tru	ıck
D36 thin 7 ne.	Completed	12					d	iesel me	echar	nic				& Tr	aile	er
5-0(led wi lygies other	S	17. Father's Name					•	1, , , *				irst, Middle, I	Maiden :	Surname)		
121 be fil ental arked	B	_	Wesley			•						entz				
MD 21215-0036 and 2 should be filed within 7 and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	은	19a. Informant's N			•			o. Mailing Addres								
and 2 lealth traun		20a. Method of Dis				20	b. Place	of Disposition (N	ame of ce			Date				own, State
nore		1 X Burial 2	Cremation Other Sp		Removal fron	State		ory or other plac Ohn's Le		ers	8/29	/2012	Wes	stmin	ster	, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	l	4 Donation 5 21. Signature of Fu			[®] ∠ M00	741		22. Name an	ıd Addres	s of Facility	El	ine Fu	nera	al Ho	me	
		Tran	da d	7	Lemy	non	<u>) </u>	934 S	. Mai	in Str	eet,	Hamps	tead	d, MD	210	
Physician Medical		23a. Part I. Enter to failure, List or	ne disease, or only one cause of	on each	line.		ath. Do no	ot enter the mode	e or aying	, such as ca	rdiac or r	espiratory arr	est, sno	ck, or near	١]	Approximate Interval Between Onset and Death
Examiner		Immediate Cause or condition resulti			orso Injurie: e to (or as a c		e of):								-	Death
		Sequentially list co	onditions,	b												
	iner	if any, leading to in cause. Enter Und	mmediate		e to (or as a c	onsequenc	e of):									
ited d ansit	Examiner	(Discass or injury events resulting in		c. Du	e to (or as a c	onsequenc	e of):									
that the death c,rrificate be executed ned by the attenting physician and detached for us, as the burial - transit	edical	UNPENDED)	1_				per me,	g932	10-2-	-12 :	sm .	Loo	D		
Box 68760, the death of crifficate be the attenting paysicited for us, as the burited for us.	Physician/Med	IF FEMALE: 23b. Was decedent past 12 month			23c. If yes, ou 1 Live birt	-	-	Fetal deat	h 3	Ectopic	pregnanc	y		. Date of d Month	Da	y Year
OX osath catten	sici			nown	4 Pregnar	nt at time of	death (Other (Sp	ecify)				1			
D. B t the da by the		Part II. Other sign	ificant conditi	ons c			ot resultin	g in the underlyin	ng cause	given in Par	t I.	23e. Did to	obacco i	use contrib	ute to th	e cause of death?
sign pe	d by											1 Yes	s 2 🗸	No 3	Proba	bly 4 Unknown
ords w requ	olete											24a. Was autop	osy	pr	ior to co	psy findings available mpletion of cause of
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	Completed											perfo 1 ✓ Yes	rmed? 2 No		eath? ✔ Yes	2 No
cian:	Be	25. Was case reference examiner?	rred to medical	IHos	spital:					e of Death (0					1	
Physical direction	P	1 Yes 27. Manner of Dea	2 No		28a. Date of	atient 2		utpatient 3	DOA 128c Inii	ary at Work?		Home 5 3d. Describe				Scene
ading th :: Afte	Certification:	1 Natural	5 Pend	ing	Aug 25, 2	n jury 012	- 1	3 hrs		Yes 2 🗹	l۹					in collision
risic r Atter her dea irector n by th	ficat	2 Accident 3 Suicide		tigation I not be	28e. Place	of Injury - A	at home, fa	arm, street, facto	ry, office I	building, etc.	. 2			nd Number	r or Rura	Route Number, City
Div ospital or hours aft uneral Di	e T	3 Suicide 4 Homicide		mined	(Specify)	Major Ro	oad / Hi	ghway			P	or Town, S eninsula Exp	State) pressw	ay at Che	esterwo	od Road, Dundalk,
田 2 年 5		29a. Certifier (Check only						ath occurred at the								
To the within To the comple	Medical	one) 2		a	n the basis of nd manner sta		rı and/or ı	nvestigation, in r		n, death occ se number	urred at t	ne time, date				h, Day, Year)
	2	29b. Signature and	a tito of certifie	1		1)4			9c. Licens					ust 25, 2		ii, Day, redij
2SC		30. Name and add	ross of norsan	who are	ne y / /	of death /!!	tem 23a)									
5		Melissa Bra						900 W. Balt	imore S	Street, Ba	ltimore	, MD 2122	23			
	ate	31. Date filed (Mor	oth, Day Xear)	9 20)12 32. Red	strar's Sigr	nature	park	1							
Regist	rar		AUU ~		~~		1									

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OUME

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			State of Maryland / Depa		ental Hygiene	0 00001
				tificate of Death	Reg. No. 20	2 30281
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Softenhar Day 07 Yea	3. Time of Death A 012 08:04 M
	Medic Examin		Ruth Anne Hill 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	
_			Meritus Medical Center	Hagerstown	Washin	
	Funeral Director		5. Social Security Number 1.56−56−2052 1. □ M 2 ▼ F 48 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.		Birthplace (State or Foreign Country)
			Usual Residence of Decedent		03/11/1964 Ne	w Jersey
	aryland a-f she fied at	ctor	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1 ★ Yes 2 □ No
	the Ma or 28a e notif	Dire	MD Washington Hagerste	10f, Zip Code	10g. Citizen of What	
	s 23a	Funeral Director	1380 Marshal St.	21740	USA	
	r item	/ Fur	Armed Forces?	Vas Decedent of Hispanic Origin? (Specif f Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.) 14. Race - A Black, W	merican Indian, hite. etc.
036	s after ral", o Exam	ed by		☐ Yes 2 X No Specify:	Specify:	White
5	2 hour "natu	Completed	15. Decedent's Education 16a. Deced	dent's Usual Occupation kind of work done during most of working	16b. Kind of Busine	ss/Industry
121	ithin 7 ene. • than	Com	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO	ONOT use retired)	None	
1d 2	iled w Il Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Surname)	
ylar	ld be f Menta arked atic ev	으	William Charles Hill	Jean El:	izabeth Nara	
Mar	2 shou th and 77 is m traum		P	ng Address (Street and Number or Rural F		
ē,	f Healt		20a. Method of Disposition 20b. Place of Disposition	Marshal St., Hagen		
m0	Page nent or ant; If ury or			Crematorium 09/11,	/2012 Smithsbur	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22	Name and Address of Facility Gera	ald N. Minnich F	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate
	Physician/		Immediate Cause (Final disease or condition E/Sen Wena	er Syndrom	e	Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Aue to or as a consequence of):	He has be color		3 336
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	truper tous on		1507
	outed nd transit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c. In the lactual	Pisahility		484
_	ite be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):	J		
760	icate t g physi	ledic	d			
89 X	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy	23d. Date of	delivery
Division of Vital Records, P.O. Box 687	re deatl the att	Physician/Me		Other (specify)	Month	Day Year
O.	that the	by Pr	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?
ds,	quires en sig ould b	ted !			1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Lunknown
CO	law re has be le 2 sh	Completed			autopsy prior	autopsy findings available completion of cause of
Re	n: The ficate or, pag		25. Was case referred to medical			Yes 2 No
Vita	ysicia s certi directo	To Be	examiner? 1	26. Place of Death (Check or	e 5 Residence 6 Other (Sp	necify)
ot	ng Ph fter th uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury		d. Describe how injury occurred	, sany,
ion	ttendi death. stor; A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
<u>X</u>	al or A s after I Direct		4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, lactory, office	3f. Location (Street and Number or City or Town, State)	Hurai Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check (Check (Check) 2 Medical Examiner: On the basis of examination and/or investigation.	igation, in my opinion, death occurred at the	e time, date and place, and due to the	ne cause(s) and manner stated.
	To the within To the Comp.		only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
				052323	09-0	7-2012
	tW-1		30. Name and address of person who completed cause of death (Item 23a) (Type, PDr. Khalid M. Waseem, MD 1126 Opal C	rint) Court, Hagerstown,	MD 21740	
	Stat Registra	e	31. Date filed (Month Carryear) . 32. Registrar's Signature .	and of		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cen	tificate of D	Death	Reg	No. 2012	302	182
1	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of D	eath
	Medic	al .	William Stuart Higgins, Jr.					9, 2012	1:04	P^{M}
	Examin	er	4a. Facility Name (if not institution, give street and number) 13825 Ideal Circle		4b. City, Town, or Hagers	Location of Death		4c. County of Death Washingtor	ı Count	v
	Funeral Director			s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 30,	9. Birth	place (State or F	
-	mc t		Usual Residence of Decedent	City, Town or Loc	-4:		200,		10d. Inside City	Limita
	Maryland 28a-f sh notified al	Director	Maryland Washington County Ha	agerstow	n				1 X Yes 2	
	h with the 1s 23a or nust be n	Funeral D	13825 Ideal Circle		10f. Zip Code 21742			U.S.A.		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Wildowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🏋 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.	
15-(72 hou "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa aind of work done of ONOT use retired)	ation Iuring most of work	ina	b. Kind of Business/In		1
72	/ithin lene. r thar the M	Con	Elementary/Secondary (0-12) College (1-4 or 5+)		Person			r Pollutio Systems Co		LOI
þ	filed wall Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Maid	_		
ylar	ld be i Menta arkec atic e	2	William Stuart Higgins, Sr.			_	et Appleman			
Nar	shou rand		19a. Informant's Name/Relationship (Type, Print)					or Town, State, Zip	Code)	- 1
e,	and 2 Healtl tem 2		Susan M. Higgins-wife 20a. Method of Disposition 20l	b. Place of Dispos	sition (Name of		gerstown,	Location - City or To	own, State	
Baltimore, Maryland 21215-0036	t. Page 1 tment of tant: If ii ijury or o		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	mithsbur	natory or other place	ory 9-11	1-2012 Sm	ithsburg,	MD	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	13	Name and Addres 331 Easte	rn Blvd.	North Hag	iery Fune erstown,	MD 2174	2 2
	Physician/ Medical Examiner	į	Section tielly list conditions	equence of):			or respiratory arrest,	eros/5	Approximate Interval Betwe Onset and De	een
	ificate be executed ng physician and as the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause							
8760	icate t physis the	Medical	d							
Box 6		Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time 1 ☐ Live Birth 2 ☐ if it is a constant at time 9 ☐ Unknown	Fetal death 3 🗕	Ectopic pregnand Other (specify)	sy .		23d. Date of deliv Month	rery Day Ye	ar
ls, P.O.	uires that th n signed by uld be detac	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobacc	co use contribute to t	he cause of dea	
Division of Vital Records,	The law ate has page 2	Completed					24a. Was an autopsy performed	prior to co death?	ppsy findings avonpletion of cau	ailable use of
ita	ysician: The is certificate director, paç	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2		Oth	ace of Death (Chec er:				
of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death 1. Natural 5 Pending 28a. Date of injury (Month, Day, Year	ER/Outpatien 28b. Time of injury	28c. Injur work	y at	28d. Describe how in	e 6 Other (Specify	9	
Division	uttend deat ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe			ies 2 🗆 NO	28f. Location (Street City or Town, St	and Number or Rura tate)	l Route Numbe	r,
_	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my km (Check only one) 3 Certifying Nurse Practitioner: To the best	ation and/or invest	tigation, in my opinio	on, death occurred a	at the time, date and pl	ace, and due to the ca	ause(s) and manr	ner stated.
	To the virthing of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configuration of the configu		29b. Signature and title of certifier		29c. Licenso	e number	29d.	Date signed (Month,	Day, Year)	
			- Ve mo		-	5599	4	9-10-12		
le	140 (30. Name and address of person who completed cause of death (I	tem 23a) (Type, P	Print)					
メ	∫ 9+1 Sta	te	L. 5a. Hissimbothan 31. Date filed (Month, Day, Year) 32. Pégistrar's Signary	gnature,						
	Registr		SED 1 1 2012	1.	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30283 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Humphrey Anne August 25 2012 ar 9:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Maryland Medical Ctr. Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 214-82-3638 Hours Director 04/24/1959 53 1 M 2 XF Maryland Usual Residence of Decedent show at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f Maryland Prince George's Clinton 1 Yes XX No ö 10f. Zip Code 10g. Citizen of What Country? pe ms 23a c Funeral 9508 Massie Drive death with 20735 USA items (11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black. White, etc. 0 1XX Never Married 2 Married þ Yes XX No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Giv White "natural", 3 Widowed 4 Divorced Completed Specify: Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Office Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Cyri1 of Health and Ment fitem 27 is marked rother traumatic e Humphrey Anna Marie Skirczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie Humphrey / Mother 9508 Massie Drive Clinton, Maryland It of Heal 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date or 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Department of Important: If any injury or 4 ☐ Donation, 5 ☐ Other (Specify) Kalas Crematory 08/28/2012 | Edgewater, Maryland 21. Signature of ral Se License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) PRIMARY BILIARY CIRRHOSIS Medical Due to (or as a consequence of) Examiner months PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ρ in the past 12 months? Pregnant at time of death Other (specify) Month Dav Year signed by the at Yes 2 X No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes XX No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1**XX**Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred XX Natural 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5 li

State Registrar

31. Date filed (

MD

S.

30. Name and address of person

29b. Signature and title of ce

Bao Bui

Greene Street Baltimore, Maryland

completed cause of death (Item 23a) (Type, Print)

29c. License number

D 74731

21201

29d. Date signed (Month, Day, Year)

08/25/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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•		1- For State Certificate of Death Reg. No.												
Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year												
Medical Examin		Kyle Andrew Hecker August 31, 2012 1650 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death												
		37798 Waterloo Road Coltons Point St. Mary's												
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or Foreign	\neg											
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or 28	Director	37798 Waterloo Road 20626 United States												
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21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'i event, the Medical	d H	3 Systems Administrator Government Contracto	r											
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2121 uld be fil Mental I marked c event,	To Be	Bruce Edward Hecker Brenda Lee Goode 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	\dashv											
MD 212 d 2 should be tth and Menta n 27 is marks		Tracy L. Hecker/Wife 37798 Waterloo Road, Coltons Point, MD 20626												
and and cealt	ı	20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	\neg											
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		4 Donation 5 Other Specific Charles Memorial Cem. 09/08/2012 Leonardtown, MD												
Balti permit. Departm Importa	ı	21. Signature Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A.	\neg											
	4	Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interv.	al											
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	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.												
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		O.C.M.E. September 1, 2012												
0 10		30. Name and address of person who completed cause of death (Item 23a)												
10 prac		Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
St Regist	tate trar	31. Date filed (Mark Pay Year) 32 Registrar's Signature												
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		Registrar	State Registrar Certificate of Death										Reg. No. 2012 3028						
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Examin	er	Holy Cros		-		4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery									
Funeral		5. Social Security No	-					If Under 1 Year If			8. Date of Bi			9. Birthpl	lace (State or Foreign	7			
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nd how at	'n	Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Town or Lo								2303	10d. Inside City Limits					
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s 23a	Funeral Director	214 Cres		20901						USA									
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uld be file Mental H narked of natic ever	To E	17. Father's Name (First, Middle, Last) Francis Joseph Sumner 18. Mother's Name (First, Middle, Maiden Surname) Mabel Virginia William										,							
nd 2 shou ealth and n 27 is n		19a. Informant's Name/Relationship (Type, Print) Bruce S. Cooper/Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37368 Shelter Drive, Selbyville, DE 19975																	
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With Toth	_	29b. Signature and title of certifier 29c. License number										29d. Date signed (Month, Day, Year)							
4										-3-	3-2012								
•		30. Name and addr		who completed cause	-				0.1	-	,		_		m				
Stol		31. Date filed (Mont		e A. Fern	andez gistrar's S			est	Gle	n Ro	ad, Si	Lver	Spri	.ng, l	MD 20910	_			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08/28/2012 MYRILE REBECCA HEIMS 4:05 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18530 Beallsville Road Poolesville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Rirth Days Min (Month, Day, Year) Director 217-44-7266 1 □ M 2 😾 F 71 Usual Residence of Deci 10/11/1940 MD in then "neturel", or iteme 23e or 28e-f show the Medical Examinar must be notified at 10a, State 10b. County flled within 72 hours efter deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Poolesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18530 Beallsville Road 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 Mo If Yes, Give Year or Dates. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Be permit. Pege 1 and 2 should be filed Department of Health and Mental Hy Importent: If Item 27 is marked otherly Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Richard Hall Dorothy Wims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph M. Helms, Sr./husband 18530 Beallsville Road, Poolesville, MD 20837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/5/2012 Jerusalem Baptist Ch.: Poolesville, MD 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service Lices 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physicien: The law requires that the death certificete be executed ate has been signed by the attending physicien and pege 2 should be detached for use as the burlet reassi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ XIo Yes 2 KNo To the Hospital or Attending Physicien: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director director director; the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>|</u>2 1 ☐ Yes 2 √x No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number toseph m. D32407 August 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Haggerty, 9707 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) State

Registrar

SEP 04 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Donna J. Herbert 08/28/2012 9:53 P M 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c County of Death Charles Indian Head 34 Chinaberry Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🔀 Hours 1 1971 1967 ountry WDC 45 578-11-3128 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits King George King George 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15045 Big Timber Rd Lot 16 22485 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🙀 No If Yes, Give Year or Dates 1 Tes 2X No Specify: Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Mill Work Representative Private 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Helen Green William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15045 Big Timber Rd Lot 16 King George, VA 22485 Franklin Herbert/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Mercer's Crematory 8/30/2012 Fredericksburg, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Cedell Brooks Funeral Home 25662 A.P. Hill Blvd P.O.Box 11 Port Royal, VA 22535 23a. Par 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

notified at

28a-f

ritems 23a or ner must be r

permit. Page 1 and 2 should be flied within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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VA

Examine burial-transi and attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Completed Be မ

<u></u> Certificate:

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifie

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 15 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year

Division of Vital Records, P.O. Box 68760

State Registrar

30. Name and address of person 0/11 31. Date filed (Month, Day

SEP 0 4 2012

who completed cause of death (Item 23a) (Type, Print) 000

32 Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P#28 2012 GERTRUDE I. HENSON 2250 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE COMMUNITY HOSPITAL CHEVERLY PG If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 220-50-8418 65 1 - M 2 X F **Director** 10-4-1946 DC Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Y Yes 2 No 28a-f MD PG CAPITOL HEIGHTS 10e. Street and Number 5 10g. Citizen of What Country? 23a Funeral 7311 SHADY GLEN TERRACE 20743 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married 9 ò 1 Yes permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced BLACK Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the DAYCARE TEACHER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ CHARLES DOMINIC HENSON MARY LOUISE MEDLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 ROVONDIA MARSHALL/DAUGHTER 7311 SHADY GLEN TERRACE, CAPITOL HEIGHTS, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Department of Important: If it any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 9-6-12 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signardre of Funeral Service License 5538 MARLBORO PIKE, FORESTVILLE, MD 01035 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metuchate Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner cancer Gastro intestinal Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Vuscular 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed 2 🗌 No Yes 2 1 Tes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 5 Pending death. Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after (determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifig D0043662 29,2012 35M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Co Hoc WILLAM prial 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785 31. Date filed (Month, Day, Year) State

Registrar

62

CEP (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joan M. Hardy ():00 A M 2011 Medical ugust 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 577-44-5743 1 M 2 X F 78 January 9, 1934 Washington, DC and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-1 snowmatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No Prince George's Berwyn Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6113 Ruatan Street 20740 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev John Delabrer Katherine Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Hardy / Daughter 329 Bay View Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9/2/2012 Alexandria, Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Atture Immediate Cause (Final Onset and Death Physician/ Va disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MCM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on. Exami physician and the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be as ding IE EEMALE nse yes, outcome of pregnancy
Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 t 12 months? 2 No Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s To the Hospital or Attending Physician: The law has autopsy performed 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending Natural s after death.

I Director: Al ed in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MIDD 6061 BSM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD LANHAM MD Good 31. Date filed (Month, Day, Year) State 32. Registrar

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar 30290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Hess, Jr. Physician/ Month Earl Wilson 10, 7:50 ÆΜ Sept. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 403 Ross Dr. Sykesville Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 219-22-2984 **Director** 1 **X**M 2 **F** 84 01/06/1928 MD 28a-f show 10b. Count with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🛛 No Carroll Sykesville MD ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 21784 USA 403 Ross Drive items death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 19 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc 1945 ò þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 Yes 2 No Specify. 1946 "natural" Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) road maintenance Baltimore City Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Mary Miller Earl W. Hess, Sr. 19a. Informant's Name/Relationship (Type, Print)
Betty Patterson/sister 19b. Mailing Address (Street and Number or Rural Route Number City or Town State, Zip Code) 403 ROSS Drive, Sykesville, MD 21784 Department of Health a Important: If item 27 is any injury or other trains Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State $\frac{1}{100}$ 9/11/2012 Carroll Cremations, 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA K V-1 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ estive 019 Cuy disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to - dica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 A Natural work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MO 33220 W 0 30 Name and address of o

Registrar

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September Physician/ 2012 11:34 A. M Harold Jordan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's St. Thomas More Nursing Facility Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Davs Hours Min. 03/22/1946 Wash.,D.C Director 578-60-9513 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural". or items 23a مه 200ء مات 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ty Yes 2 ☐ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1845 Harvard St., N.W. 20009 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johnnie Jordan Sylvia Parler 19a. Informant's Name/Relationship (Type, Print)
Yvonne J. Murphy/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4314 Urn Street, Capitol Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 09/10/12 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service Licenses Name and Address of Eacilly Henry S. Washington & Sons Co., Inc. Jany rall CC0316 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Cargrooma throat with JQUAMOUS Physician IRARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 G the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be tailore 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 🗷 No 1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Hospital: 2 X No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death.

I Director: Af id in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, within 24 hours a To the Funeral D To the Hospital Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number Signature and title of certifier

DHMH 17 Rev 7/2009

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Jeffers. Α. Jr. 29 рм 2012 August 5:47 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11809 Indigo Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Country 192-32-8631 Director 1 🗚M 2 🗆 F 72 Yrs. June 13, 1940 PA ed other then "natural", or items 23a or 28e-f show event, the Madical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Directo 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral l1809 Indigo Road 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black White etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1958-62 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 is and Mental Hygiene.
7 is marked other then "n Elementary/Secondary (0-12) College (1-4 or 5+) 4 Engineer Government Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert A. Jeffers, Sr. Laura G. McFeely end 2 should the Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet V. Jeffers/Wife 11809 Indigo Road, Silver Spring, MD 20906 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: if its eny injury or of Gate of Heaven Cemetery 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 4, 2012, 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funer I Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Brain Cancer Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Exami To the Hospitel or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-remails. attending physician and for use es the buriel-renei Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 🗆 Yes 2 🖾 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 24 D68686 Sept. 1, 2012

State

Registrar

2101 Medical Park Drive, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Frederick Min, MD

SEP 04 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 31 Day 2012 ear 12:01 A.M Physician/ **JACOBS** Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death P0tomac c. County of Death Montgomery Examiner Potomac Valley Nursing Home 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** NewitrYork Days Hours Augnth, 28 Year 1918 94 105-12-6878 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Rockville 10a. State 10b. County within 72 hours after death with the Maryland Director Montgomery MD 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ian "natural", or items 23a o Medical Examiner must be U.S.A. Funeral 20854 5 Arlive Court 12. Was Decedent Ever in U.S. WWI I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates. US Army Specify: Completed 3 X Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with... Mental Hygiene. '⊶d other than "r ≺, the M (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Clerk emit. Page 1 and 2 should be filed eportment of Health and Mental Hyg important: If item 27 is marked other only njury or other traumatic event, onc. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Goldberg ၉ Louis Jacobs 19b Mailing Address (Street and Number or Rural Route Number City of Town, State, Zip Code) 5 Arlive Ct., Rockville, MD 20854 19a. Informant's Name/Relationship (Type, Print)
Robin Hein / daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Mt. Lebanon Cemetery 1 X Burial 2 Cremation 3 Removal from State Sept.3,2012 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Signature of Funeral Salce Licens 254 Carroll St., NW, Washington, DC 20012 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between ause on each line. Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying n and Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Parkinson's Disease Completed page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: the Hospital or Attending hin 24 hours after death. injury 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) August 31, 2012 29b. Signature and title of certifier 29c. License number D38262 5+1

Registrar
DHMH 17 Rev 7/2009

State

9043 Shady Grove Ct., Gaithersburg, MD 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Anurita Mendhiratta,

SEP 04

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30^{Day} Physician/ Auq 20°12 5:45 p M George Carroll Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) MD Country) **Funeral** Days Hours Aug. 14, 1924 219 16 2461 88 1 🖾 M 2 🗆 F Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director Lexington Park 1 Yes 2 No or 28a-f MD St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral with 20653 46136 Thompson Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? → Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc marked other than "natural", or Completed by 1 Never Married 2 Married Black Maryland 21215-0036 1 Yes 2 No Specify 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fuel Inspector Federal Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Ethel Allen Johnson Jordan Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Paragon Ct. Upper Marlboro, MD 20772 19a. Informant's Name/Relationship (Type, Print) S 8558 Paragon Ct. Fran Johnson/ daughter permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date DOSCATOR 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 9-5-2012 Lexington Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Priscoe-Tonic Funeral Home 21. Signature of Funeral Service Lidensee rece 38675 Brett Way Mechanicsville, MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** WEEK Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 SEONGE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death signed by the 1 ☐ Yes ≥ ☐ Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE PRIVAL FAZLURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DEMENTZA autop-performer After this certificate has director, page 2 ASPIRATION ANEUMONZA 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 8/30/2012 064840 LEONAMATOWN MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT GISSON MO ST MARY'S HOSPITAL 25500 POINT LUCKOUT NO Registrar

2102/02/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 MACO: 80 **YVETTE** JOHNSON RENEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore Johnson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex Days Hours (Month, Day, Year) Country) 578-88-3920 Director 1 🗆 M 2 🖾 F 51 22, 1960 DC Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Event in a must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Clinton Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Renee Funeral 20735 9661 Gwynndale Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) g Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Program Analyst 12th Be Know Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Allen Patricia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, MD 20735 Warren Johnson - Husband 9661 Gwynndale Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8-31-2012 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Insetand Death Physician/ disease or condition resulting in death) GANGRENOUS

Dut to (or as a consequence of): HOLECYSTITIS Medical Examiner REPRACTOR Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL DISEASE ON HEMODIALYSIS Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my entities. The state of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August, 23,2012 M-D RES-000 i San Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Sinai Balwan M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG'27

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09704/2012 10:02a M Charles Kerns, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Monique's Assisted Living Beltsville Prince Georges . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 07/12/934 579-48-1005 78 Director DC Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits at Director ms 23a or 28a-f s must be notified 1 XYes 2 No Beltsville MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 11329 Frances Drive USA "natural", or items edical Exa⊓iner mu death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lizzie Akers Frank Kerns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $m MD = 2\,0\,7\,4\,0$ 19a. Informant's Name/Relationship (Type, Print) Rose Mae Yates - Sister 6100 West Chester Pk Dr. #1104 College Park other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/12/2012 LANDOVER, MD Harmony 21. Signature of Funeral Service Licensee

Wanda C. Bacon CC0361 22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Malignant Neoplasm of bronchus and lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a nonsecuence of burial-trai Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Vear 1 L Yes 2 L 9 L Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 ☐ Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 45M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD Branch Ave TEMPLE HIL BROWN EMMANUEL 4467 31. Date filed (Month

DHMH 17 Rev 06-2011

State Registrar

Registrar's Signature

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

29a. Certifier

30. Name an

(Check

only one

31. Date filed (Monta

3

29b. Signature and title of certifier

Medical Examin

Certifying Nur

23a) (Type, Print)

use of death

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. L

er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month

, 18111 Prince Philip Dr., Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30298 Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death Physician/ 2012 Jean Karolick August 30. 3:25 P M Karen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MedStar Montgomery Medical Center Montgomery If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 098-42-7344 1 □ M 2 🗓 F 62 March 12,1950 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 18525 Strawberry Knoll Road 20879 United States items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. ō 1 Never Married 2 X Married 2 X No þ Maryland 21215-0036 1
☐ Yes :
If Yes, Give 1 Yes 2 No Specify: Specify: "natural", 3 Divorced 4 Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Strawberry Knoll and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Elementary School Administrative Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marion Rothrock traumatic Arthur Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other. Ronald Karolick/Spouse 18525 Strawberry Knoll Rd., Gaithersburg, MD. 20879 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 09/03/2012 | Alexandria, Virginia Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ADENOGARCINOMA OF Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of: tany Lading to Immediate cause. Enter Underlying Cause (Disease or injury and The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No ó Month Year Pregnant at time of death by the a 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE LUNG DUCENSF 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed? death? certificate 1 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director, After of completely filled in by the funer Natural Accident work? 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tith 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY O. EHIABOR IMD, 18101 Prince Philip Drive, Olney, Maryland 20832

State

Registrar

31. Date filed (Month, Day, Year)

SEP 05 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Departmen	ırtment of Health and N <i>tificate of Death</i>	Aental Hygiene Reg. No	
Physic		Decedent's Name (First, Middle, Last) James KANEGIS		2. Date of Death August 31,52	2012 Year 3. Time of Death 10:45 a M
Med Exam		4a. Facility Name (if not institution, give street and number) 119 Shaw Ave.	4b. City, Town, or Location of Death Silver Spring	4c Mc	. County of Death Ontgomery
Funera Directo	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Number 99 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 7,1913	9. Birthplace (State or Foreign Country) New York
yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Montgomery Silver	SPring		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ith the Mai 3a or 28a t be notifi	Funeral Director	10e. Street and Number 119 Shaw Ave.	10f. Zip Code 20904	10g. Ci	tizen of What Country?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ted by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	Jas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work DNOT use retired) ist	ing	ind of Business/Industry
rland the filed was fined the filed was fired other tic event,	To Be	17. Father's Name (First, Middle, Last) Louis Kanegis	18. Mother's Nam	e (First, Middle, Maiden CCa We	_{Surname)} ersky
, Mary id 2 should saith and N n 27 is ma er trauma			g Address (Street and Number or Run haw Ave., Silver		Town, State, Zip Code) 20904
imore Page 1 an ment of He ant: If iten ury or oth		4 Donation 5 Dother (Specify)	Mem. Garden Sept	.4,2012 Fa	
Balt permit. Depart Import any inj		21. Signature of Fiver Stryice Licensee 22 Why Bigure 25	Name and Address of Facility To 4 Carroll St., NV	orchinsky He I, Washing	ebrew Funeral Home ton, DC 20012
- Physician	,	23a. Part 1. Enter the disease, or combications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acute Myocardial		or respiratory arrest,	Approximate Interval Between Onset and Death
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uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
760 icate be executed physician and ts the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence of): d.			
Box 68 death certif	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, P.O. irres that the signed by the lid be detach	b	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the significant conditions contributing the significant conditions contributing the significant conditions contributed the significant conditions contributed the significant conditions conditions contributed the significant conditions contributed the significant conditions contributed the significant conditions conditions conditions contributed the significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditi	nderlying cause given in Part I.		use contribute to the cause of death? X No 3 Probably 4 Unknown
Division of Vital Records, ral or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a signed as a should be a signed as a should be a signed as a specific at the funeral director, page 2 should be a signed as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific as a specific	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
/ital F sician: T certifica lirector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Chec		
on of \nding Phy ath. :: After this ie funeral o	icate: To	27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury 2 Accident Investigation	28c. Injury at work? M 1 Yes 2 No	28d. Describe how injur	
Divisic al or Atte s after des la Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
le Hospit n 24 hour le Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of the basis of examination and/or invest only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invest only one)	igation, in my opinion, death occurred a	t the time, date and place	e, and due to the cause(s) and manner stated.
TO + within	. -	29b. Signature and rive of certifier	29c. License number	29g Da	te signed (Month, Day, Year) WSF-31, 2012
V		30. Name and address of person who completed cause of death (Item 23a) (Type, P. Jerome Schnapp, MD 11161 New Hampshii	re Ave., #201, Si	lver Spring	,MD 20904
Si Regis	ate trar	31. Date filed (Month, Day, Year) SEP 0 4 2012 32/Registrar's Signature	Med.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eccard 3013 Month ande 0715A M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Julia Manor Hagenestown HealthCorer Washington Lenter If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 215-18-1174 Hours 89 **Director** 1 D M X D F Nov. 16, 1922 Maryland items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Washington Smithsburg 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11808 St. Mary's Court 21783 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian or than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 l n and Mental Hygiene. **7 is marked other than "n** (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simon P. Eccard Mollie M. Lewis and 2 should by Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23502 Leathers Rd. Smithsburg, Md. 21783 Nelson L. Spessard (Nephew) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory Date 1 Burial 2 Coremation 3 Removal from State Sept 4 Donation 5 Other (Specify) Smithsburg,Md. Signature of Funeral Service Licen 22. Name and Address of Facility 12525 Bradbury Ave. Deller. J.L. Davis Funeral Home M01414 Smithsburg Md Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Atheroscleratio disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be the as attending IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 5 Other (specify) _ Month Dav Year be detached 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 📈 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 9 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Terrifying Prinstrain: 10 the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, P-353 Mill Street, Havenstown

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Yea SEP 2 1

Please Type or Print in Black dodelible trik 2 Engure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea Physician/ Month HELEN JANE LANDON 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa. /i S Sara Village at 5. Social Security Number COMI 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 10/18/1928 Days Hours Min Director 213-24-4737 1 🗆 M 2 🔀 F Virginia item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 611 Tressler Drive - Room 302 21801 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ل المركبار برماير كركا Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify. Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bradley Landon Lorraine Crockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Howard (Cousin) 8351 Hilda Drive - Salisbury, MD 21804-2218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Mem. Park 08/29/2012 Crisfield, MD . Signature Funeral Service Liebbee Robert H. Bradsh 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, MD Bradshaw, Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 To the Hospital or Attending ring around within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached. g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 2 8 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept 3,2012 ay Physician/ 0230 amM James Legette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington 2221 Rosedell Place 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Numbe **Funeral** Feb 20,1941 South Carolina Director 1 🔀 M 2 🗆 F 248-50-7869 71yrs 28a-f show 10a. St MD 10b. County Prince Georges 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Fort Washington 1 Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 20744 2221 Rosedell Place ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2xx No If Yes, Give Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after Black. 1 ☐ Yes XX No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Services 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gracie Gause Butch Legette 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1521 Spring Pl W Washington DC 20010 Randy Legette(SON) item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 Department of H Important: If ite any injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 9, 2012 Mullins, SC Devotion Garden 5 Other (Specify) Signatur 22. Name and Address of Facility Lee Funeral Home 6633 Old Alexandria Ferry Rd Clinton Md 20735 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Ente shock, of he Approximate Interval Between Onset and Death Immediate Gause (Fige Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours: firer death.

To the Funeral Linector. After this certificate has been signed by the attending physicis completely filled in by this funeral director, page 2 should be detached for use as the build completely filled in by this funeral director, page 2 should be detached for use as the build. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Dav Year Pregnant at time of death 2 No g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XX Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31, Date filed (Month, Day, Year) State

(Check

1170/ livingita Rd ybi, ft wastington MD 20740 MA ida ROW.

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D45365

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ september 8 2012 9:27P David Bryan Luman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Country) 220-52-1204 Director 1 XXM 2 □ F 62 2-22-1950 Louisiana iral", or items 23a or 28e-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Point of Rocks 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3724 Kanawha Ave. 21777 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Å Xyes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 permit. Pege 1 end 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", eny Injury or other treumetic event, the Medical Exer 1 ☐ Yes 2XX No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lab Tech Medical Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estil Homer Luman Anne Mae Huguley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Sauer - Sister 593 Grouse Knoll Lane, Summit Point, WV 25446 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory Date 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State 9-11-2012 Hagerstown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Moo970 Eackles-Spencer & Norton Funeral Home Ferry, WV 254 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Immediate Cause (Final Onset and Death Physician Vegan Medical resulting in death) Due to (or as a consequence of) Examiner enc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). URGRS the Hospital or Attending Physician: The law requires that the death certificate be executed iven attending physician and I for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Day Year Yes 2 No the detached g Unknown P.O. ۾ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sinal director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check and title of certifier 30. Name and address of person what completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	20	12 30304
			Registrar 1. Decedent's Name (First, Middle, Last)	andate of Boats	Reg. No. 2 U	3. Time of Death
	Physicia Medic	al	Lai Chun Wong Lee			Year 012 7:25 p ^M
1	Examin	er	4a. Facility Name (if not institution, give street and number) Lins Assisted Living	4b. City, Town, or Location of Death Gaithersburg	4c. County of Montg	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		213-84-6786 1 □ M 2 SM F 69 Yrs.	Months Days Hours Min.	(Month, Day, Year) April 16, 1943	Country) China
	and show 1 at	-	10a. State 10b. County 10c. City, Town or Lo	ecation	<u> </u>	10d. Inside City Limits
	Maryl 28a-f otifiec	ireci		er Spring		1 🗌 Yes 2 🛣No
	ith the	ralD	10e. Street and Number 2853 Cairncross Terrace	10f. Zip Code 20906	10g. Citizen of Wh	·
	eath w	Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		- American Indian,
30	be filed within 72 hours after death with the Maryland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	è	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Black, Specify:A	White, etc. sian
5	hours natura Jical E	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	16b. Kind of Busi	iness/Industry
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Maryland 21215-0036	of and 2 should be file of Health and Mental H fitem 27 is marked of rother traumatic even		. I'	ng Address (Street and Number or Rur	·	
	and 2 Health tem 2		20a. Method of Disposition 20b. Place of Dispo	Cairneross Terrae	_	ity or Town, State
Ē	Page 1 nent of ant: If it ury or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State Gate of		t. 6.	Spring, MD
Baltimore,	permit. Page Department of Important: If any injury or once.	İ	21. Signature of Eunerel Service Literature e	Name and Address of Facility ins 0 University Blvd	Funeral Home In	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
. 1	Physician/	91 B	Immediate Cause (Final disease or condition Alzheimer's Disea	se		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
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õ ×	th certi tendin or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3		23d. Date Montl	
. Box	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bonglitransit	Physician/Med	1 ☐ Yes 2 🖾 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)	North	n bay real
	that the	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu	ute to the cause of death?
rds,	law requires nas been sigr e 2 should be					Probably 4 🛭 Unknown
Kecords,	e law n has b ge 2 st	Completed			autopsy prie	ere autopsy findings available or to completion of cause of ath?
ř	s ician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical	26. Place of Death (Chec		Yes 2 No
Vital	S S	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing H	Ass ome 5 Residence 6 X Other	isted Living (Specify)
n of	ding P h. After ti funera	Certificate:	27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
Division of	Attenar deat sector:	rtific	2		28f. Location (Street and Number	or Rural Route Number,
2	ital or irs afte al Dira	100	building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invert only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	at the time, date and place, and due to	o the cause(s) and manner stated.
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P	•		y Glober W	D37142	Sept. 4	, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type G. Coleman, MD 1355 Piccard Drive,	Rockville, MD 20	850	
	Stat		31. Date filed (Month, Day, Year) SEP 0 6 2012 32. Registrar's Signature			
	Registra	ir	SET UU LUIZ GENERA P. MARIE			

12-06840 Stevie Levin

2-06840		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
tevie Levin		State of Maryland / Department of Health and Mental Hygiene 1- For State Reg. No. Reg. No.
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) Stevie LEVIN 2. Date of Death Month Day Year September 10, 2012 3. Time of Death 0956 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Thurmont 4c. County of Death Frederick
Funeral Director		5. Social Security Number 220-70-6322 6. Sex 1. Months Days Hours Min. July 10, 1958 Foreign Country) PA
daryland 28a-f show any Lat once,	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Thurmont 1 ☐ Yes 2 ☒ No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	ral Director	10e. Street and Number 15928 St. Anthony Road 10f. Zip Code 21788 10g. Citizen of What Country? United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
rs after death ' ural'', or item	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Filed and Mental Hygiene. In province it filem 27 is marked of the "matural", or items 23a or 28a-fahe injury or other traumatic event, the Medical Examiner must be notified at once	To Be Co	17. Father's Name (First, Middle, Last) Howard Levin 19a. Informant's Name/Relationship (Type, Print) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Chasen Street and Number or Rural Route Number, City or Town, State, Zip Code)
ore, MD ges I and 2 sho of Health and If item 27 is ther traumati		Barbara Levin, Wife 15928 St. Anthony Road, Thurmont, MD 21788 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 09/13/12 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: Witer injury or other tr		4 Donation Falls Church, VA 21 Symmetric Fuleral Service Licersee WOLUDE 12: Name, and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC, 20012
Physician /Medical £xaminer		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
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Box 68760, death certificate be decentle attending physician and defor use as the burial - tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
J. B. the de by the ached f		1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?
cords, P.C law requires that has been signed	Completed by	1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an autopsy
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To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Fara	N.	29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 11, 2012
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 14 2012 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	,	State of Ivi	aryland /		tificate o			na ivi		_	.201	2	30300	5
	Physicia	ın/	1. Decedent's Name (First, M									2. Date of De Month	Da		ear	3. Time of Death	Ī
- Andrews	Medic Examin		HAROLD 4a. Facility Name (if not instit		et and number)		AMRE	CRT 4b. City, Tow	n, or L	ocation of	Death	AUGUS		20, 20 c. County of		2:58p "	_
لمرسا			FREDERICK	MEMOR	RIAL HO	SPTTA	T.	FRED	ERI	ICK If Under 24			F	REDE	RIC	'K	
	Funeral Director		5. Social Security Number 216-78-2499	6. Sex	7. Ag	e (In yrs. last t		If Under 1 Y Months Da			4 Hrs. Min.	8. Date of Bir (Month, Da		g	. Birth	place (State or Foreign try)	
			Usual Residence of Deced		M 2 🗆 F	64	Yrs.					01/17/	1948	We	est	Virginia	
	yland -f sho ed at	ctor	10a. State 10b. Co			10c. City, To	own or Loc deric								1	0d. Inside City Limits	
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	with the s 23a c ust be	Funeral	6205 Fairfa	x Court	t			217					_	· S. A		itry r	
	death ritems nerm		11. Marital Status		. Was Decedent I Armed Forces? 1 \(\sum \) Yes 2 \(\begin{array}{c} \begin{array}{c} \text{Yes} \\ \text{2} \end{array}	Ever in U.S.	13. V	Vas Decedent Yes, specity (of Hisp Suban,	oanic Origir Mexican, I	n? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - A			
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ed by	1 XNever Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		1 Yes 2 XI If Yes, Give Year or Dates.	No	1	☐ Yes 2 X	No	Specify:				Specify: \			
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, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Rela Linda Lewi					g Address (Str								^{Code)} 21048	
nore	Page 1 alment of H tant: If iter iury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot		moval from State	ceme	tery, cren	sition (Name o natory or other n Memor	place)			ate /2012		ocation - Cit	-	wn, State Maryland	
Baltimore,	permit. P Departm Importar any injur	3	21. Siz harvre of Funeral Sen		NV	Level	22	. Name and A	dress	of Facility	St	auffer	Fur	neral	Hom	e, P. A.	2
			23a. Part 1. Enter the disease shock, or heart failure.	se, or complica	itions that caused	d the death. De								ick,	Mar	yland 2170 Approximate	_
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1	Medical Examiner		resulting in death)		Due to (or as	a consequenc	e of):									1 Week	
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	icate be executed i physician and is the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as	a consequenc	e of):										_
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687		/Me	IF FEMALE:	230	. If yes, outcome	of pregnancy											Т
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours at er death. To the Funeral Director. After this certificate has been signed by the attending completely filled by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No. 9 Unknown		1 Live Birth 4 Pregnant a	2 Fetal de		Ectopic preg Other (specif					Î	23d. Date o Month	f delive	ery Day Year	ıl.
Ö.	hat the ed by detac	y Ph	Part II. Other significant co	nditions contri	buting to death b	out not resultin	g in the u	nderlying caus	e giver	n in Part I.		23e. Did to	obacco	use contribut	te to th	e cause of death?	_
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SCOL	has be	Completed										24a. Was	psy	24b. Were prior deat	r to coi	osy findings available inpletion of cause of	
Ä	Physician: The law this certificate has ral director, page 2		25. Was case referred to med	lical					Disc	4 D 11	(0)	1 L Yes	rmed? 2 🔼 N	o 1	Yes	2 🗆 No	
Vita	ysicia s cert	To Be	examiner? 1 Yes 2X No		pital: X Inpati	ent 2 ER/	Outpatien		Other:	e of Death		ne 5 🗆 Resid	dence (S □ Other /9	necify.		_
Division of Vital Records,	ding Ph h. After thi funeral		27. Manner of Death 1X Natural 5 P		28a. Date of inju (Month, Day	ry 28b	. Time of injury	28c. I	njury a		28	3d. Describe h			,peeny,	-	
isio	er deal ector by th	Certificate:	3 🔲 Suicide 6 🗆 C	vestigation ould not be etermined	28e. Place of Inju		farm, stre								r Rural	Route Number,	
á	urs at rral Di		*							_	1	City or Tow					
	the Host in 24 ho the Fune	Medical	(Check 2 ☐ Medi only one) 3 ☐ C erti	cal Examiner: fying Nurse P	n: To the best of On the basis of e ractitioner: To th	xamination and	d/or invest	igation, in my o	pinion,	death occu	urred at the	ne time, date a	and place	e, and due to	the cau	ise(s) and manner state	d.
	Not Not Con		29b. Signature and title of ce	rtifier				29c. Lic						ate signed (M) $^{\prime}21/20$		Day, Year)	
			30. Name and address of per	son who comp	oleted cause of d	eath (Item 23a	ı) (Type, P	rint)	-								_
	ى		Rachel Madri				Str	eet, Fi	ede	erick	, Ma	ryland	217	01			
	Stat Registra		31. Date filed (Month, Day, Ye SEP	0 5 2012	1 12	ar's Signature	1	arkel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	yland / De	partment of F	lealth and N	/lental Hyg	iene 20	12	30307
			Registrar 1. Decedent's Name (First, Middle, La			ertificate of E	veatn	2. Date of Dea	ieg. No.		
	Physicia	n/	_	,				Month	Dav	Year	Time of Death
	Medic Examin		James 4a. Facility Name (if not institution, giv	Lyons e street and number)		4b City Town or	Location of Death	August	28, 201 4c. County		9:38 P ^M
	Examili	ei	Bel Pre Health	· ·	ation		er Spring			gomery	
	Funeral		Social Security Number 6.		n yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace	(State or Foreign
	Director			1 🟋 M 2 □ F 8	6 Yrs	Months Days	Hours Min.	(Month, Day,		Country)	
	ld now	پ	Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or	Location		April 9	, 1926]		ston, VA
	arylar a-f st fied a	Director	District of Co		Washir						Yes 2 No
	or 28	Dire	10e. Street and Number	Idinota	Washiri	10f, Zip Code			10a. Citizen of W		
	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral	3005 Bladensbur	g Road, NE		20018	}		United	States	}
	items items	Fun	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	Was Decedent of Hi If Yes, specify Cuba				- American Inc	dian,
9	after (I", or kamir	l by	1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2 😾 No		,		Black	
3	atura cal E	Completed	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.	16a De	cedent's Usual Occup					
212	an "n Medi	mpl	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4 or 5+)	(G	ve kind of work done of DO NOT use retired)	uring most of worki	ing	16b. Kind of Bu	siriess/iridustry	
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n	filed al Hy d oth	э Ве	17. Father's Name (First, Middle, Last)				18. Mother's Name				
Maryland 21215-0036	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e	인	Little John Lyo	n			Bertna	Jackson	L		
Mai	shou h and 7 is n traum	i	19a. Informant's Name/Relationship (1	ailing Address (Street a					
	and 2 Healt em 2		Karion Lyons - W	1Ie		05 Riggs Ro		Date	20c. Location -		State
Baltimore,			1 🔀 Burial 2 🗌 Cremation 3 [cemetery, c	rematory or other place Mem. Cemt	e) !	6, 2012			
≣	permit. Pag Department Important: any injury c	ď	4 ☐ Donation 5 ☐ Other (Specal 21. Signature of Funeral Service Licer		BINCOIL	22. Name and Addres					
ñ	Dep Imp any onc	15	John T. Steva		00560	4001 Benni				-	
			23a, Part 1. Enter the disease, or cor shock, or heart failure. List only		ne death. Do not	enter the mode of dying	g, such as cardiac o	or respiratory arre	est,		roximate rval Between
A.	Ph _y sician/		Immediate Cause (Final disease or condition	_ Hyperte	nsion						et and Death
	Medical Examiner		resulting in death)	Due to (or as a c							
		ř	Sequentially list conditions,	b							
	ed sit	mine	cause. Enter Underlying Cause (Disease or injury	Due to lor as a c	onse juence off						
	ecute and	Еха	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):						
20	death certificate be executed re attending physician and ed for use as the burial-transit	dical Examiner	•	■ d.							
-	ficate g phy as the	(D)	IS SERVICE	- 4.							
χ	endin r use	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2		3 Ectopic pregnance	V			e of delivery	
X R R	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown		5 Other (specify)			Mon	th Day	Year
j	that the ned by the e detach		Part II. Other significant conditions	contributing to death but	not resulting in ti	ne underlying cause giv	en in Part I.	23e Did to	Dacco use contri	oute to the cal	use of death?
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ğ	requii been shouk	ete						24a. Was a			ndings available
Vital Records,	e law e has ige 2	Completed				*		autops	me <u>d</u> ? p	rior to complet eath?	tion of cause of
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N I	ysicis is cert direct	To Be	examiner? 1 Yes 2 X No	Hospital:	t 2 🗆 ER/Outpa	Othe		ome 5 🗆 Reside	ence 6 🗆 Other	(Specify)	
0	ng Ph		27. Manner of Death 1 ♣Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	28b. Tim	of 28c. Injury	at	28d. Describe ho			
0	tendir eath. or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not	on		M 1 🗆	Yes 2 No				
DIVISION	or Att	Certificate:	4 Homicide determined			street, factory, office		28f. Location (St City or Town		or Rural Rout	e Number,
ב	pital ours eral [29a. Certifier 1 Certifying Ph	ysician: To the best of my	v knowledge des	th occurred at the time	date and place at	nd due to the car	se(s) and manne	er as stated	
	e Hos n 24 h e Fun bletely	Medical	(Check 2 Medical Exar	niner: On the basis of exar rse Practitioner: To the b	mination and/or in	vestigation, in my opinio	n, death occurred at	t the time, date ar	d place, and due	to the cause(s)	
	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	<	29b. Signature and title of certifier		1 A A	29c, License	·		9d. Date signed	- 5.	
			> more		M.D	05	7313		91	5/12	_
	2504		30. Name and address of person who	completed cause of dear	th (Item 23a) (Typ	e, Print)	in KI	1: Mi	1/21 1	16 h	2010
	_		21 Date filed (Month, Day Year)	= 1055	cher	nace or	vive p	11WIL	259 10	- 01	072.
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	signature	gila)		
	-3.0		3 - 1 3 - 203	71.		•				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Michael Mowery Jr. Joseph Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. Hours **Director** 219-30-4959 75 1 👿 M 2 🗆 F Dec. 21, 1936 Maryland Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Fishing Creek 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2512 Old House Point Road 21634 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married δ 1 ☐ Yes 2 🕱 No If Yes, Give white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates Baltimore, Maryland 21215-0 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natury or other traumatic event, the Mexical any injury or other traumatic event, the Mexical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) service writer automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Michael Mowery Dora Zarnowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Mowery wife 2512 Old House Point Rd, Fishing Creek, MD 21634 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorchester Mem. Park Date 20c. Location - City or Town, State . Page 1 1 X Burial 2 Cremation 3 Removal from State 9/7/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Bervice Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the ca Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of eause of autopsy ☐ Yes 2 N 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 No မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) TERN SHUKE 10 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar	Strar Certificate of Death Reg. No. 201							30303
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		12	3. Time of Death
	Medic	al	Klara Marie 4a. Facility Name (if not institution, give s	-		41. Oits Tassa as	Location of Death	August	26, 20 4c. County		6:00 a ^M
	Examin	er	17527 Old Gettysbu			Emmits			1 .	reder:	ick
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Mar 5,	Year)	9. Birthp	place (State or Foreign
	Director		213-42-1711	□ M 2 X F 83	Yrs.	Working Bays	Triburo IIIIII	1929	Gen	many	
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Aaryla 8a-f s tified	Director	Maryland Freder	rick			Emmits	burg			1 ☐ Yes 2 🗙 No
	a or 2 be no	<u>=</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	h with	Funeral	17527 Old Gettysbu				21727			US	
_	r deat or iten iiner i		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 No			ispanic Origin? (Spe an, Mexican, Puerto			e - America ck, White, e	
ဗ္ဗ	safte ral", c Exan	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	I ☐ Yes 2 🕱 No	Specify:		Specify	wh.	ite
<u>ဂ</u>	2 hour	plet	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup	ation during most of work	ing	16b. Kind of B	usiness Inc	dustry
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<u>Jan</u>		2	Albert Bachels				Anna	Linden			
Maryland	shc is		19a. Informant's Name/Relationship (Typ	•			and Number or Run		-		Code)
	1 and 2 f Health item 27 other tr		Pauline Engelstatt 20a. Method of Disposition			Ladys 'I'ra	ail, Fair		20c. Location		Num State
Baltimore,	. 0 + -		1 💢 Burial 2 □ Cremation 3 🗆 I		ametery crer	natory or other place		- 1	Emmits	-	·
	permit. Page Department Important: I any injury o once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License								
ñ	lmp any any		Austi R.I	Survolue		210 W Mai	ss of Facility My in St, Em	mitsburg	, MD 2	1727	
			23a Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the deat	h. Do nt ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
1	nysician/		Immediate Cause (Final disease or condition resulting in death)	Lisbolde	Oc	ille M	yound	ul In	faich	~	Onset and Death
	Medical Examiner		resulting in death)	Oe to (or as a conseq	uence of):	at		1,000			Williams
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	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Hyper	tena	ha					30 years
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8	certific nding use as	~	23D. Was decedent prednam	3c. If yes, outcome of pregna		7			23d. Da	ate of delive	ery
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Э. Э.	it the o	Phy	9 ∐ Unknowň Part II. Other significant conditions con		sulting in the u	inderlying cause alv	ven in Part I	230 Did tol	acco use cont	tribute to th	ne cause of death?
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<u>e</u>	ian: Th	Be C	25. Was case referred to medical examiner?			26. Pf	ace of Death (Chec		2 131/10	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 🗆 140
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Division of Vital Records,	Jing P. J. After t funera	Certificate:	27. Manner of Deat 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe ho	w injury occurr	ed	
<u> </u>	Attend r death ctor: y the	rtific	2. Accident Investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At he	ome, farm, str		res 2 🗆 NO	28f. Location (St		er or Rural	Route Number,
\leq	al or safter		4 - Hornicide determined	building, etc. (Specific	y)			City or Towr	n, State)		
_	Hospit 4 hour Funerated fill	Medical	(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examination	n and/or inves	tigation, in my opinio	on, death occurred a	t the time, date an	d place, and du	ie to the cai	use(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of m	y knowledge,	death occurred at th	e time, date and pla	ce, and due to the	cause(s) and m	anner as sta	ated.
	# 3 # 8		▶ (81/ ~	IV M	29c. License number 29d. Date signed (Month, Day, Year)					12	
7	Ale		30 Name and address of person who co			Print) B.	7.1	ALA A	513.5		
Ŋ,	714		Hlan Carroll	01- 3001-	mAre	Emm	usburg	MID	21/2)		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture 4	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a per med cert G933 11/28/12 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ Adaline May Mills $\mathbf{p}^{\,\mathsf{M}}$ 2012 3:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9895 Crossfield Road Hagerstown Washington If Under 1 Year If Under 24 Hrs.

The Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) 213-12-7605 **Director** 91 Yrs. 1 M 2 X F 10/10/1920 Maryland Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 5 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be by Funeral 9895 Crossfield Road 21740 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper **Hospitality** other of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virgie May Lowman Raymond Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Myers / Daughter 594 Falling Waters Drive, Falling Waters, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any Injury or otl cemetery, crematory or other place, 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Oth St.Paul Lutheran Cem. 09/12/2012 Leitersburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between t and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Nephrosclerosis Sequentially list conditions, Examine Due to for as a consecuence of cause. Enter Underlying Cause (Disease or injury that initiated events Hypertension burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atte Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes been Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy 1 Yes 2 No 1 Yes Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 **II** No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

29b. Signature and title

Cam

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dical

29c. License number

DO026579

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 8 2012 15:52 Ethel Wilma Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County 1018 Matthew Ct. Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 214-09-0950 Director 1 🗆 M 2 💢 F 93 June 12,1919 Canada Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ian "natural", or items 23a or Medical Examiner must be Funeral 1018 Matthew Ct. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 XWidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 F of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Childs Newey Ethel Ada Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar.
Important: If item 27 is u 5 Woods Rd. Elkton, MD 21921 William C. Zinkand-nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Smithsburg Crematory 9-11-2012 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses MD 21742 Eastern Blvd. North Hagerstown, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Oue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 100 9 Unknown signed by the 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? death? 2 ANO Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other 1 Yes 2 / 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending 1 Yes 2 No filled in by the ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

DHMH 17 Rev 06-2011

71U-10

Date filed (Month)

29b. Signature and title of certified

RANCISC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDMADE

29d. Date signed (Month, Day, Year)

LAGERSTONIN, MO 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Megan C. Morris		S 1- For State Registrar	tate of Marylan		ment of icate of		id Mental F		Reg. No.	2012	3031
Physicia Vedical Examii	11.2	Decedent's Name (First, Midd Megan Christ 4a. Facility Name (if not institution)		3				2. Date of Dea Month August 30	Day 0, 2012	Year	Time of Death 1734 hrs
3 -		4a. Facility Name (if not institution St. Mary's Hospital	on, give street and numb	per)	4	b. City, Town, or Leonardtov	r Location of Dea VN	th	4c. Cour St. Ma	nty of Death ary's	
Funeral Director		5. Social Security Number 219–08–3313	6. Sex 7.	Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Day		in.	/1983	Foreign	olace (State or trMaryland
w any		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov						11	0d. Inside City Limits
Maryland 28a-f show	rector	Maryland St. M 10e. Street and Number	lary's	Mechai	nicsvi	10f. Zip Code		Т.	10g. Citizen of		Yes 2 No
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral Director	27430 Birch Ma 11. Marital Status 1 Never Married 2 N	12. Was Deced	es?			spanic Origin?(s n, Mexican, Puerl	Specify Yes or No			S n Indian, Black,
ē F	à	15. Decedent's Education (Spe			a. Decedent		specify: tion (Give kind of DO NOT use re			fy: White Business/Ind	
77	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle			Homema	_	19.Mother's Nam	·	Own Maiden Surna	Home	
21215-()036 and be filed within 7 Mental Hygiene, marked other than c event, the Melica	Be	Philip Phillip Walker 19a. Informant's Name/Relations	Carroll	1	19b. Mailing	Address (Stree	Kathle				ip Code)
and 2 sh and 2 sh fealth an item 27 item 27 item 27	-	James Philip M		and 20b. Plac	27430 e of Disposi	Birch M	anor Ci		chanic		MD20659
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Crematio 4 Donation 5 Other S 21. Signature of Juneral Service	pecify:	Olate	atory or oth sfield 22. Na		Cre 09/	06/2012	Charle	otte Ha	all, MD
Physician	\dashv	Edward N. Brin 23a. Part I. Enter the disease, of failure. List only one cause	r complications that caus	M00052 sed the death. Do	not enter th	55 Holl e mode of dvina	ywood Ro	oad, Leo	nardtov	wn MD	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	T-+	tion			codone a	inu mesa	таштие		Death
F 15	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co								
D, be execut sician and	edical	X UNPENDED		a, 27, 28a per th		r_me_129	31 9-25- vt amen	12 sm d item		fh g97	2 2-4-16 v
Box 6876(e death certificate the attending physed for use as the b	Physician/M	23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 ✓ Un	4 Pregnant	at time of death		al death 3 er (Specify)	Ectopic pregr	nancy	Month	n Day	/ Year
ires that the d signed by the	출	Part II. Other significant condi	tions contributing to de	eath but not result	ing in the ur	nderlying cause	given in Part I.				e cause of death?
tal Records.	Completed	-						1 ✓ Yes	osy rm <u>ed</u> ?		osy findings available apletion of cause of
ing Physi ling Physi After this	å P	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	Hospital: 1 Inpa	njury 28t y,Year)	Outpatient Time of In	3 DOA	of Death (Check Other Nurs In at Work? Yes 2 X No	ing Home 5 28d. Describe	how injury occ		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	cal Certification	3 Suicide 6 S Coudete 4 Homicide 29a. Certifier 1 CertifyIng P	Id not be rmined 28e. Place of (Specify)		home	ed at the time, d	ate and place, an	d due to the cau	se(s) and man	ner as stated.	Route Number, City h Manor Lle,MD.
To the within To the compl	Medical	one) 2 Medical Example 29b. Signature and title of certific	aminer: On the basis of e and manner state er		r investigati	29c. Licens O.C.	se number	at the time, date		gned (Month,	
Deme		30. Name and address of persor Patricia Aronica-Polla	k MD. Assistant	of death (Item 23a Medical Exa		900 W. Baltir	more Street,	Baltimore, M	D 21223		
Sta Regist	ate rar	31. Date filed (MSEP) (earl	2012 32 Regis	trar's Signature	par	w					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State	State of Marylan	•	nt of Healt te of Deatl		Hygien Reg. N	2011	30313
	Registrar 1. Decedent's Name (First, Middle, Las	t)	- Och timod	ic or beau	2. Date	of Death		3. Time of Death
Physician/ Medical		LLS, III			Aug	just a		01253AM
Examiner	4a. Facility Name (If not institution, give Aurorg Senior			y, Town, or Location	4	4	Somer	th cat
Funeral	5. Social Security Number 6. S		st birthday) If Und	er 1 Year If Und	der 24 Hrs. 8 Date	of Birth	9. Bir	thplace (State or Foreign
Director		X M 2 □ F 52	Yrs. Months	Days Hour	09/2	h, Day, Year 5/1959	Mar	yland
and show lat	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				1	10d. Inside City Limits
Maryla 28a-fa otified irect	Maryland Somers	set	Crisfield	£				1 Yes 2 □ No
3a or the the the the nation	10e. Street and Number 1 Village Drive -	Apartment 1	10f. Z	ip Code 21817		10g. (Citizen of What Co	ountry?
leath with the Maryland items 23a or 28a-f shoer must be notified at Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	i. 13. Was Dec		Origin? (Specify Yes o	r No-	14. Race - Ame	erican Indian,
by smin	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		ecify Cuban, Mexi		.)	Black, Whit Specify: Wh	ite, etc. ite
21215-003 rithin 72 hours at lene. r than "natural" the Medical Ex	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Us (Give kind of w life. DO NOT u	ork done durina m	nost of working	16b.	Kind of Business	/Industry
212 Within giene. The N the N	Elementary/Secondary (0-12)	College (1-4 or 5+)	None	se retired)		No	one	
and 2 be filed wental Hyg ked othe c event,	17. Father's Name (First, Middle, Last)			18. Me	other's Name (First, Mi	ddle, Maide	n Surname)	
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Amary Mary d 2 should alth and M	Kevin Evans (Frie		1		Avenue - (-		
Get and of Hex	20a. Method of Disposition 1 Burial 2 Cremation 3	20b. P	lace of Disposition (Nemetery, crematory or	ame of	Date		Location - City or	
ti. Pag rtment rtant:	4 Donation 5 Other (Special	y) Cre	matory of				elmar, <u>I</u>	DE
	21. Signatur of unsal Service Lens Robert H. Brads	haw, jr	1306 W	. Main St	is Funeral .—Crisfie	ld, MI	21817	
(1)	23a. Part 1. Enter the disease, or com shock, or heart failure. List only c Immediate Cause (Final	plications that caused the death ne cause on each line.			as cardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
Physician/ Medical	disease or condition resulting in death)	a Due to (or as a consequ	ence of):	CVA				syian
Examiner	Secuentially list conditions		vere 05	structie	sleep ap	ner		15year
760 tate be executed physician and stree burial-transit edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):	norbid C	sleep ap			20 years
be exe	resulting in death) Last	Due to (or as a consequ	lence of):	lancer	<i>(</i>			
3760 ficate by g physical as the bandic		d						
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🔲 Ectopi				23d. Date of de Month	elivery Day Year
P.O. s that the gned by t be detach	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given in P				o the cause of death?
rds, rds, rds, rds, rds, rds, rds, rds,								Probably 4 🗆 Unknown
Ehn Mills on of Vital Records, ending Physician: The law requires sath. or: After this certificate has been sig the funeral director, page 2 should b						Was an autopsy performed? Yes 2	prior to death?	utopsy findings available completion of cause of
rital sician: certific irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector; irector	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Other:	Death (Check only one			
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the Hospital in 24 hours the Funeral npletely filled	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of my knowliner: On the basis of examination se Practitioner: To the best of m	and/or investigation, ny knowledge, death o	n my opinion, deat courred at the time,	h occurred at the time, , date and place, and di	date and pla ue to the cau	ce, and due to the ise(s) and manner	cause(s) and manner stated. as stated.
To to to to to to to to to to to to to to	29b. Signature and title of certifier	Chi	2	9c. License numbe			Date signed (Mont	/
O DA	30. Name and address of person who		23a) (Type, Print)	0051	J>7	/	tugast a	N12
	DR. USHA NATTS			MAN	RUAD, S.	AUSB	ury 2	i 804
State Registrar	31. Date filed (Month, Day, Year) AUG 2 8	32. Registrar's Signat	TOUNT HE				·	

Physician /Medical Examiner

Funeral Director

Physician /Medical

Registrar						C	ertifica	te of	Death				Reg. No	20	12	3	031
1. Decedent's Na			,	_							IV	ate of De lonth _	Da		Year		ne of Death
BURDE'			MALLO				4h Cit	. Town o	r Location	of Death		UG	31	201 County of			40PM M
-	DUNST	_					40. 010	BOW		or Death			40	-	PG		
5. Social Securit 577 2 2		6. Se	х] м 2 ў г	7. Age (II	-		Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. D	ate of Bir Nonth, Da R 2	th v, Year)				ate or Foreign
577 22 Usual Residence			- W 254		94	Yrs					MA	R 23	3 15) 18 F	T. [A I.	1011	VAIVIA
10a. State	10b. Count	ty		10	oc. City,	Town o	Location						-			_	de City Limits
MD		PG			B	OWI											¥es 2 □ No
10e. Street and I	Number DUNST	ABL	E CT.				10f. Z	ip Code 2.0	0721				10g. Ci	tizen of Wh US		intry?	
11. Marital Statu			12. Was Dece		r in U.S.	. 1	I3. Was Dec			igin? (Sp	ecify Y	es or No	-	14. Race	- Amer		ın,
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3X Widowe	d 4 Divorce		Year or D	ates:		10- D							10h 10	Specify:		ACK	
	15. Decede pecify only high	est grad	ie completed)			(0	ecedent's Us live kind of w fe. DO NOT	ork done	during mos	st of work	king			ind of Busi		-	
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17. Father's Nar													Maider	Surname))		
CHARI		UCK								EOPA				ETT			
VALORI	Name/Relation	SSOI SSOI	Vipe. Print) TYLE	R			ailing Addre										20016
20a. Method of I				1:	20b. Pla	ace of D	sposition (N	ame of	1		Date		20c. L	ocation - C	ity or T	own, Sta	te
1 ☐ Burial 4 ☐ Donatio	2 Cremation	3 🗆 1	Removal from	04-4-													
	n 5 ∐ Other ((Specify		State	RIV	(ERI	TORY	PARK	re) ;	9/5/	/12		RIV	ERDA			
	Funeral Service)				22. Name	and Addre	ss of Facili	ty		<u> </u>			2	2001	0
21. Signatur of	Funeral Services the disease.	e Liceps	ications that o	CCO	527	7	22. Name	and Addre	ss of Facili	ty 35 I	14t	h S	T N			2001 DC	kimate
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State Registrar Glen

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M. Jacob

SEP 0 6 2012

DHMH 17 Rev 1/2001

1221 Morcountile Live Largo MD 20774

D0059633

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No. 2 0 1 2

		-	For State Registrar	State of Maryland	•	irtment of He tificate of De			giene Reg. No. 2	012	30315
F	Dis state	/	Decedent's Name (First, Middle, Last)					2, Date of De Month		Year	3. Time of Death
	Physicia Medic	al	Paul J.	Makovica				Septem	ber 1,	2012	10:40 A ^M
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21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ted		If Yes, Give Year or Dates. 194.	5				Spec	Whi	
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Baltimore,	of Hex of Hex if item ir othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Ren	20b. Pla	ce of Dispos	sition (Name of natory or other place		Date		on - City or To	
<u>H</u>	t. Page tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)			tan Crem.					Virginia
Ba	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service Licensee			Name and Address East Dee					m 20877
			23a Part 1. Enter the disease, or complica							urg, r.	Approximate Interval Between
	Ph _y sician/		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	Metastatic P	rostai	te Cancer					Onset and Death months
	Medical Examiner		resulting in death)	Due to (or as a conseque							
		er	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a conseque	nce of):						
	ansit ansit	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events		,						
	ian and		resulting in death) Last	Due to (or as a conseque	nce of):						
200	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d								
89	certific nding use as		IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnand		1=			23d.	Date of deliv	ery
Box 68	e atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
P.0.	at the c d by th etache	Phy	9 ☐ Unknown Part II. Other significant conditions contril		tina in the u	nderlying cause give	en in Part I.	23e Did t	tobacco use co	ontribute to t	ne cause of death?
α. σ.	signed d be d	d by	, a			, , ,		1 🗆	Yes 2 □ N	o 3 🗆 Pro	bably 4 🔀 Unknown
ord	v requi	olete						24a. Was			psy findings available mpletion of cause of
Division of Vital Records,	The lay	Completed							ormed?	death?	
tal	cian: 7 ertifica ector,	Be (25. Was case referred to medical examiner?	oital:		26. Pla	ce of Death (Chec	k only one)			
j V	Physi this c eral dir	<u>유</u>	I LI Yes 2 IAJ NO	1 ☐ Inpatient 2 ☐ E	R/Outpatien 28b. Time of	t 3 DOA Other	4 L Nursing H	ome 5 K Resi 28d. Describe)
o uc	nding ath. r: After	icate	1 ☒ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	work?			,,		
Visio	ir Atte ter de irector n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or To		mber or Rura	Route Number,
Ö	pital o		29a, Certifier 1 X Certifying Physicia	n: To the best of my knowle	dae death o	occurred at the time	date and place	and due to the o	eause(s) and m	anner as stat	ed
	e Hos n 24 ho e Fun oletely	Medical	(Check 2 Medical Examiner:	On the basis of examination a cactitioner: To the best of my	and/or invest	igation, in my opinior	n, death occurred a	t the time, date	and place, and	due to the ca	use(s) and manner stated.
		-	29b. Signature and title of certifier			29c. License			29d. Date sig		
	12+1		1 mg.	Won			3828		Septem	ber 4	2012
			30. Name and address of person who comp Dr. Dongmei Wang, M	- 1/			fve. Sui	te 435	. Rocks	rille.	MD. 20850
	Sta	te	31. Date filed (Marth, Day (eas) 2012	3. Registrar's Signatu	re L	V.	. <u> </u>	200 700	, MOCKV		
	Registr	ar	SEP UD LUIZ	Kenus B.	14 61	A COUNTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Bertrand H. MERWIN 2012 7:00 P September Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death
Montgomery **Examiner** Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year 1 If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 102-05-6903 1 M 2 □ F **Director** 95 New York 28a-f shov items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 1262 Cresthaven Drive 20903 United States death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) General Law Attorney traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Celia Groskin Jacob Merwin Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) Hilda Merwin, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 1262 Cresthaven Drive, Silver Spring, MD other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 09/04712 Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Capital Hebrew Cemetery National Capitol Heights, MD 21. Signature of Fureral Service Lindinsee Forchinsky Hebinew Funeral Home DON 254 Carroll St., NW, Washington, DC 20012 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Aortic Stenosis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypotension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events the burial transit Metastatic Prostate Cancer Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Chronic Kidney Disease Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Wunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how Injury occurred To the Hospital or Attending 1 X Natural 5 Pending 1 Tyes Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29d. Date signed (Month, Day, Year, September 2, 2012 D 65953

State Registrar 1500 Forest Glen Road, Silver Spring, MD

rson who completed cause of death (Item 23a) (Type, Print)

M.D.

<u>Onukogu</u>

SEP 04 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month McAuliffe, Jr. William James 201 4:00 AM A112. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5701 Rockmere Drive Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) 90 Director 023-16-8597 1 XM 2 F Yrs Jan. 18, 1922 Massachusetts Usual Residence of Decedent I and 2 should be filed within 72 nous and 4 Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "Medical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Md. Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5701 Rockmere Drive 20816 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 DXYes 2 Nol 943-Black, White, etc. 1 Never Married 2 X Married <u>&</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Association Executive Trade Association Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William J. McAuliffe Caroline E. Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 Rockmere Dr., Bethesda, Md. 20816 Catherine T. McAuliffe/Wife injury or other Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Gate of Heaven Cem 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 4, 2012 Silver Spring, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I Month Immediate Cause (Final Physician/ Metastatic Melanoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin ing physician and e as the burial-tenest The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day 4 Pregnant at time of death signed by the at the detached f Yes 2 No g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 쥰 Records, Completed should 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1x No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2X No <u>ء</u>ِ| 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Sign

Registrar

State

12+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Cohen, M.D.,

SEP 04

31. Date filed (Month, Day, Year)

29c. License number

MD7600

3800 Reservoir Rd., NW., Washington, DC 20007

29d. Date signed (Month, Day, Year)

August 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ James Vaughn Marx L, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) (Month, Day, Year, 219-48-0195 1 🛮 M 2 □ F Director May 14, 1949 Washington D.C. Usual Residence of Decedent show. 10c. City, Town or Location Frederick 10a. State notified at Director MD Frederick 1 Tyes 2 No 28a-f 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6440 Merchantile Drive E. Apt. 110 21703 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Examiner Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates. 1977 "natural", 3 🗌 Widowed 4 💢 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Functional Specialist US Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Franklin H. Marx Alice McNulty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health Tiffany King (Daughter) 11419 Woodview Drive, Hagerstown, MD 21742 20a. Method of Disposition
1

Burial 2

Cremation 3

Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Smithsburg Crematory 9/7/2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keleney & Bas Folkd P.A. Funeral Home 106 E. Church St., Frederick, MD 21701 MO1612 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mebsiella preuvoniae UTI with SepTICEMIA Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' Yes 2 No e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lawithin 2 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

5x

muly Decell

Francisco

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELS DO

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

MeriTUS

10061117

Nedical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29c & 29d per MD FCHD TM 9/5/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lloyd Gilman McIntire Month au Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5 Galyn Drive Brunswick Frederick 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 549-48-1135 73 1 X M 2 □ F Yrs May 25, 1939 California 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene if them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21758 USA 5 Galyn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗆 No 1988 Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐√No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Navy Captain US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Kenneth McIntire Genevieve Youngman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Galyn Dr., Brunswick, MD 21758 Frances McIntire / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Derartment of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2012 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licenstee 22. Name and Address of Facility Stauffer Funeral Home all 1100 North Maple Ave., Brunswick, MD 21758 Pa. 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a lock, or hear failure. List only one cards are nearly line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): [/]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should t Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, in 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Other: 2 No ပ္ 3 🗆 DOA 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 🗌 Yes М 2 🗌 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Stated. Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the to the course(s) and manner as state.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time date and place, and the to the course(s) and manner as state. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) August, 28, 2012 D22019 who completed cause of death (Item 234) (Type, Print) Lloyd, Halvorson, MD Name and address of 5 31. Date filed (Month, Day, State 32. R oistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pegible State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 3. Time of Death 4:45P M Physician/ Malcolm J. Matthews Da 0 2 Year 2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Worcester Home Pocomoke City Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral X**XM 2 □ F Days Hours 214-30-9481 81 1/2011/2011/1930 MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes X No MD Somerset Pocomoke City 10e. Street and Number 10g. Citizen of What Country? Funeral 32829 Peach Orchard Rd. 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Religion Priest should be filed with and Mental Hygien I is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thera Nina Malcolm George Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Kathy Malloy Breithut/Niece P.O. Box 765, Pocomoke City, MD, 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 109/06/2012 | Salisbury, MD Funeral ervice Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. The 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on e Immediate Cause (Final Griset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical the attending ploched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 \sum Yes ည Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this (1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending in 24 hours after deam.
The Funeral Director: Aft 1 🗌 Yes 2 🗍 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sign 54422 09-04-2012 30. Name and address of person who completed cause of de BA lot 604- Mar 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ee Edward Ma	xwe	1- For State Registrer Certificate of		, ,	_{g. No.} 2012 3032
Physici Medical Exam		Dec Lawara Maxwerr		2. Date of Death Month September	
		4a. Facility Name (if not institution, give street and number) 501 68th Ave	4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince George's
Funeral Director		5. Social Security Number 216198559 6. Sex 17. Age (In yrs. last birthday) 32 yr	If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth	h(MM/DD/YYYY) 9. Birthplace (State or Foreign District Country)
Aaryland 28a-f show any 1 at once,	tor	Usual Residence of Decedent 10a. State	asant		10d. Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number 501 68th St.	10f. Zip Code 20743	1	g. Citizen of What Country? U.S.A.
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiers, and mit. If item 27 is marked other than "matural", or items 23a or 23a-fabour other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? If 1 Yes 2 MNo 3 Widowed 4 Divorced If Yes, 2 WNo 1 Or Dates: 1	as Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - American Indian, Black, White, etc. Specify: Black
5-0036 led within 72 hours Hygiene. other than "natur	Completed I	15. Decedent's Education (Specity only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mail	nt's Usual Occupation (Give kind of v nost of working life. DO NOT use reti Clerk		16b. Kind of Business/Industry Government
1215-0036 I be filed within 7 ental Hygiene. arked other than arked the Medica	Be	Larry Lee Maxwell	18.Mother's Name Jane B.	Polla	rd
MD 21 and 2 should I salth and Mer m 27 is mar	ဥ	Michelle Maxwell Wife 501	g Address (Street and Number or I 68th St. Seat sition (Name of cemetery,	Pleasa	nt, MD 20743
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med		1 X Burial 2 Cremation 3 Removal from State crematory or o Coleman	Cemetery 9/1	5/2012	20c. Location - City or Town, State Alexandria, VA
M	6 6	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Spontaneous retro	orrissette-Joh	ITTID I	Bell & Winona 20607 •A. 2107 Carl + Acceltre K. M st, shock or heart mplicating Between Onset and
Examiner	2. (0	Immediate Cause (Final disease or condition resulting in death) aEnd—Stage renal Disease or condition resulting in death)	ise		Death
ted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
O, e be execu ysician and burial - tra	ledical	M UNPENDED AMENDED 23a, 27, per me,	g931 9-25-12 sm		
Sox 6876 death certificat te attending phy I for use as the	Physician/Me	Pregnant at time of death	etal death 3 Ectopic pregna ther (Specify)	incy	23d. Date of delivery Month Day Year
P.O. es that the igned by the detache	ð	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? 2 No 3 Probably 4 Vunknown
Division of Vital Records, P.O. Balloviel and Physician: The law requires that the rad catter death. I provide the straight of the law requires that the rad ballow of the law requires that the rad ballow of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of the law of t	Completed			24a. Was an autopsy perform	prior to completion of cause of death?
Vital tysician this cert directo	To Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check of Donald Other Donald Other Nursin	, ,	esidence 6 🗸 Other: Scene
ion of Vital literating Physician: teath. tuer: After this certif		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day,Year) 28b. Time of			w injury occurred
E E P	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre (Specify)	et, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rural Route Number, City te)
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, death occu			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 10, 2012
Ba-2		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900	W. Baltimore Street, Baltin	nore, MD 212	23
	ate	31. Date filed (Month Pay, Year) 4 2012 32. Fegistrar's Signature	W.		

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amended #28a.per physician on 9/4/2012 cchd/ba
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ **0105** M Benjamin Gerd Mrongowius 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cente. rauma IMP Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral Director** 1 🛛 M 2 🗆 F 215-31-2254 Oct. 11, 1990 Virginia 21 Usual Residence of Deced 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director Maryland Bryans Road Charles 1 Yes 2 X No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20616 1605 Marshall Hall Road U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married 1 Yes 2 No by Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed White Year or Dates Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Student and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marken any injury or care. <u>pe</u> Lisa Marie Eddy Holger Gerd Mrongowius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Marshall Hall Road, Bryans Road, Md. 20616 Lisa M. Mrongowius Mother altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27, 2012 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FallsChurch, Virginia National Memorial Park 21. Signature of Fune Williamsdrimeral Home, P.A. Vist M00668 4270 Hawthorne Rd., Indian Head, Md. lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart fail Immediate Cause Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Exami CATION APPROVED BY MEDICAL EXA burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 JE FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No g 🗌 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No this certificate Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 I DOA မ 2 🗌 No Manner of Death 28b. Time of 28a. Date of injury 28d. Describe how injury occurre Certificate: 8c. Injury at 24 hours after death. Funeral Director: After work?
1 Yes 2 No Natural 5 Pending 1145 PM 2 Accident Investigation the 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State) 8305 Cedarville Rd, Brandywine, MD Driving on road Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 8/23 Kes oo

State

Registrar

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Name and address

31. Date filed (Mor

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ise of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year haben Physician/ D M 1217 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 232-58-5846 1 🛛 M 2 🗆 F **Director** 08-04-1939 West Virginia 73 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 Yes 2 X No Huntingtown MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a Funeral USA 1800 Holland Cliffs Road 20639 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. Ö 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced White Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Parts 12 Auto Parts Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lelah Pearl Armstrong Laben Jackson McCartney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 1800 Holland Cliffs Road, Huntingtown, MD Elizabeth A. McCartney, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/1/2012 Alexandria, VA 21. Signature of Funeral Service Licegsee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 M00715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumon disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** COPD Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transit law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month 5 Other (specify) Pregnant at time of death teen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has perform 1 ☐ Yes 2 ☐ No I or Attending Physician: The after death.

Director, After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 2 X No 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🔼 Inpatient 2 🗌 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31 00061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRID 10 100 Hospital Road, Prince Frederick, MD 20678 M.D., Chang Choi,

State Registrar 31. Date filed (Month, Day,

Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Queene11 Walker McClain 2012 10:20 PM September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16102 Parklawn Place Prince George's Bowie If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Aug. 30, 9. Birthplace (State or Foreign Country)
South Carolina **Funeral** 047-28-3352 Days **Director** 1 M 2 M 2 77 1935 Yrs Usual Residence of Decedent 28a-f shov 10b. Count notified at 10c. City. Town or Location Director District of Columbia Washington 1 X Yes 2 No the 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20020 1721 38th Street, SE United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 2 Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Specify Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Librarian Government vears marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rueben Walker Annie Bay permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16102 Parklawn Place Bowie, MD 20716 Jeinine R. McClain - Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State Page 1 1 K Burial 2 Cremation 3 Removal fr Edistow Fork U. Meth Ch Cent 9/10/2012 Orangeburg, SC 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T. Stews **Q** M00560 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_{sician} disease or condition resulting in death) Renal Failure Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical requires that the death certificate be P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Year 2 **X**No the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Records, 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build in the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the autopsy performed death? or Attending Physician: The 1 Yes 2 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's examiner? Hospital 1 🗌 Yes 2 🗆 XNo Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) House this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 XNatural 5 Pending work n 24 hours after death. e Funeral Director: A letely filled in by the fi 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 within 2.

To the F
complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057264 September 5, 2012

DHMH 17 Rev 06-2011

State

Registrar

55.n

30. Name and address

R.

31. Date filed (Month, Day, Year)

Lucas,

6 2012

Tiffni

Barks

5530 Wisconsin Avenue Suite 1149 Chevy Chase, MD 20815

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 | 2 30325 State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Moot NB Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Hospice of Chesapeake Linthicum If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 578-30-0144 85 Yrs May 7, 1927 Washington, DC 27 is marked other then "neturel", or items 23a or 28a-f show treumetic event, the Medical Examinar must be matthed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 #D409 16010 Excalibur Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 0. Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 No If Yes, Give 1 Baltimore, Maryland 21215-0036 Year or Dates. 1945 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager - Paint Shop Pepco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Taylor Henry McCabe Ida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 McCabe 1325 Treasure Dr. Odenton, Md 21113 permit. Page 1 and 2 Department of Health Important: if Item 27 any Injury or other tr Ronald 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pege 1 6 Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/7/12 Lincoln Cemetery Brentwood, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home ranc Veta II 3401 Bladensburg Rd Brentwood, Md 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any leading to immedia cause. Enter Underlying ettending physician and for use as the burial-transit Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ned by the et detached fo Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2**i**🖵 To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 1 N 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospitel or Attending 1 Hatural 2 Accident (Month, Day, Year) 5 Pending work? 1 ∐ Yes 2 ∐ No after death Investigation 3 ☐ Suicide 4 ☐ Homîcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the l only one) Configure Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Pom ntem 23a) (Type Print) WNAPOLISMD. 21401 0 Registrar's Signatu State Registrar

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30326 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0810 Medical Francis Mullen Donald 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-RMC Cumberland 8. Date of Birth (Month, Day, Year) Sep 28, 1928 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** Director 1 🙀 M 2 🗆 F 198-20-5773 83 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 X Yes 2 No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a USA 21502 915 Brown Avenue 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1946 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite dical Examiner 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1948 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Audio World owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernadette Drass Samuel Mullen and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 MD 21502 915 Brown Avenue Cumberland Ruth Mullen wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 9/6/2012 St. Patrick's Cemetery Cumberland MD 8 ☐ Other (Specify) signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA icensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part E ter the disea of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Adem carcin onga Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is Yes 2 XN Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Medical Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSAM SEMAAN

31. Date filed (Month, Pay, Year) SEP 2 1

WMHS 12500 Wilbubrook Rd. Cumber and, MB Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Grate of	iviai yiaii		tificate of L	Death			2012	30327
	Physicia		Decedent's Name (First, Mide EVELYN	dle, Last) T •		NEWSON			2. Date of Dea Month SEPT .		2012 Year	3. Time of Death 5:10 AMM
	Medic Examin		4a. Facility Name (if not institution			NEWSON	4b. City, Town, or	Location of Death	DIII I .	$\overline{}$	County of Death	
			WOODSIDE NUR				SILVER				ONTGOMER	
	Funeral Director		5. Social Security Number 579-26-3371 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01-29-1	h v, Year) L926		nplace (State or Foreign Intry) ANDRIA VA
	and show 1 at	or	10a. State 10b. Coun	ity	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f otified	Director		E GEORGE'S	FOR	ESTVIL		<u></u>				1 X Yes 2 No
	th the		10e, Street and Number				10f. Zip Code				zen of What Cou	untry?
	ath wi	Funeral	3741 DONNELL 11. Marital Status	DRIVE 12. Was Decede	nt Ever in U.S	3, 13. \	207 Was Decedent of H	74/ ispanic Origin? (Spe In, Mexican, Puerto	cify Yes or No-		5 . A . 14. Race - Amer	ican Indian,
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorc	Armed Force	es? □ X No		f Yes, specify Cuba I ☐ Yes 2 💢 No		Rican, etc.)		Black, White	
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Baltimore, Maryland 21215-0036	Page 1 al ment of H. ant: If itel ury or oth		20a. Method of Disposition 1 XX Burial 2 Crematic 4 Donation 5 Other	r (Specify)	ate HAR	emetery, crer MONY M	esition (Name of matory or other place EMO. PARE	(9-8-2		LANI	Cation - City or DOVER, N	1D
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	e Licensee	CO203			ss of Facility PIN				
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that caust only one cause on each	ised the deat line.	h. Do not ent e	er the mode of dyin	g, such as cardiac c	or respiratory ar	rest,		Approximate Interval Between
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00	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	d. DEMEN								
98760	rtificat ing ph e as th	/Mec	IF FEMALE:	00.16								
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 5th bours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	□ 23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Feta	al death 3 🛚	Cther (specify)				23d. Date of deli Month	ivery Day Year
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Division of Vital Records,	ul or Attending Physician: The la after death. Director: After this certificate ha d in by the funeral director, page.	Certificate	3 🔲 Suicide 6 🗆 Cou	uld not be 28e. Place of	Injury - At he , etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tou			al Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 Medica	ing Physician: To the bes al Examiner: On the basis ing Nurse Practioner: To	of examinatio	n and/or inves	tigation, in my opinie	on, death occurred at	t the time, date a	and place,	and due to the c	cause(s) and manner stated.
		_	29b. Signature and title of certi		5	2	29c. Licens		2	29d. Dat	Γ . 5, 20	, Day, Year)
	3		30. Name and address of person	on who completed cause	of death (Iten	n 23a) (Type, I						20850
	tek.		PATRICIA GOM		ietrarle Cian	turo #		SHADY G	ROVE RD	. #13	30 ROCK	/ILLE, MD
	Sta Registr		31. Date filed (Month, Day, Year	2012 Jene	istrar's Sign	ture	de l'					

nthony Orris		State of Maryland / Departing 1-For State		Hygiene	201	2 3032
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	odic of Death	2. Date of Deat		3. Time of Death
ledical Exam	iner	Anthony Orris		Month Septembe	Day Year r 4, 2012	1620 hrs
		Facility Name (if not institution, give street and number) 2327 East Preston Street	4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24H Months Days Hours Mi		h(MM/DD/YYYY) 9. Bir Foreid	
		212-62-0693 1 M 2 F 59 Usual Residence of Decedent	Yrs. World's Days Hours Wil	Sept.	21 , 1952 °	Washington D.C.
w any		10a. State 10b. County 10c. City, Tov	n or Location			10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 2327 East Preston Street	10f. Zip Code 21215	10	g. Citizen of What Cour	ntry?
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5-0 led wi Hygier other		17. Father's Name (First, Middle, Last)		ne (First, Middle, M	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	George Orris		Vohur		
, MD 21215-0036 and 2 should be filed within 72 hours aftereath and Mental Hygiene. ten 27 is marked other than "natural", traumatic event, the Medical Examiner	To		9b. Mailing Address (Street and Number or P.O. Box 637, Bryans			Zip Code) 20616
nore, MD ages 1 and 2 sh ent of Health an out: If item 27 i		20a Method of Disposition 20b Place	of Disposition (Name of compton)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Metr	opolitan Funeral Ser	012 vice	Alexandria	, Virginia
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Icensee	22 Name and Address of Facility Williams Funeral H			
		Modellan Model8	4270 Hawthorne Rd.	. Indian	Head, Md.	20640
Physician /Medical		26a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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587(srtifica ling ph	- 	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Y ear
(ecords, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physiciage 2 should be detached for use as the buri	Physicia	1 Yes 2 No 9 Unknown Pregnant at time of death	5 Other (Specify)			
P.O. B s that the de gned by the	F	Part ii. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tob	 acco use contribute to t	ne cause of death?
s, P.O. nires that the n signed by d be detach	ed by	Diabetes Mellitus		1 Yes	2 No 3 Proba	ably 4 🗹 Unknown
tal Records, cian: The law requir certificate has been sector, page 2 should la	Completed			24a. Was ar autopsy	prior to co	opsy findings available ompletion of cause of
Rec The la	E			perform 1 Yes 2	ned? death? No 1 ✓ Yes	2 No
Vital ysician: his certifi director,	Be	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)		
f Vi Physi er this ral dir	2	1 Yes 2 No	Outpatient 3 DOA Other Nursin		esidence 6 🗸 Other:	Scene
Division of Vital ral or Attending Physician: rs after death. al Director: After this certi red in by the funeral director	Certification:	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	28d. Describe no	w injury occurred	
Vision Attender der der der der der der der der der	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	arm, street, factory, office building, etc.		eet and Number or Rur	al Route Number, City
Divis	E E	4 Homicide determined (Specify)		or Town, Sta	te)	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do one) 2 Medical Examiner: On the basis of examination and/or				
To t To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d Date signed (Moni	
\sim		and -	O.C.M.E.		September 5, 201	
20/01	1	30. Name and address of person who completed cause of death (Item 23a)				
anx,	[Ana Rubio M.D., Ph. D. Assistant Medical Examine	r 900 W. Baltimore Street, Baltin	more, MD 212	23	
Sta	ate	31. Date filed (Mont) Per Year) 7 2012 32. Rigistrar's Signature	backer			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	cer	tificate of l		ivientai Hyg	Reg. No. 20	12	30329
	Physicia		1. Decedent's Name (First, Midd Mylous Sexter	· ·				2. Date of Dea		Year	3. Time of Death 9:55 a M
	Medic Examir		4a. Facility Name (if not institution		Community	4b. City, Town, o	r Location of Deat		4c. County	of Death	7.33 am
			Collington Epi 5. Social Security Number	scopal Life		Mitche1					rge's
3	Funeral Director		415-14-3749	6. Sex 1 M 2 □ F 7. Ag	90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 922	g. Birthp Count Tenne	place (State or Foreign try) Nashville essee
	and show 1 at	or	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or Loc	cation				1	0d. Inside City Limits
	Maryla 28a-f	Director	DC N/A	A	Washingto	n					1 X Yes 2 □ No
	with the 23a or ist be r	eral D	10e. Street and Number 1435 4th St. S	W		10f. Zip Code 20024	ŀ		10g. Citizen of \ United		•
(0	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent I Armed Forces? 1 M Yes 2	1 1	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)		e - America ck, White, e	
21215-0036	ours aft rtural", al Exar	eted t	3 Widowed 4 X Divorce	d If Yes, Give Year or Dates	1-19-42 2-07-46	☐ Yes 2 🔀 No			Specify.	B1a	ıck
215-	n 72 ho e. man "na Medic	Completed		ent's Education lest grade completed) College (1-4 or 5	(Give I	lent's Usual Occup kind of work done (D NOT use retired)	during most of wo	rking	16b. Kind of B	usiness Ind	lustry
21	d withi	Be Co	17. Father's Name (First, Middle,	5+		sicist				_	Research
/lan	d be file dental l irked o ric eve	To	Mylous Sexter	•			Sadie	me (First, Middle, I Couch	Vlaiden Surname	1)	
Man	2 should be th and Ment 27 is marked traumatic e		19a. Informant's Name/Relations Nicole O'Dell					ral Route Number,		tate, Zip C	iode)
Baltimore, Maryland	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t		20a, Method of Disposition		20b. Place of Dispos			Date Date	20c. Location -	City or To	wn, State
ţ	t. Page tment rtant: I		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	Congressi	onal Ceme	etery 09-	-15-12	Washin	gton	. D.C.
Ba	Depar Impo		21. Signature of Fuderal Service	Licensee				CGuire F			
	Ph_sician/		Immediate Cause (Final	only one cause on each line	d the death. Do not ente	r the mode of dyin					Approximate Interval Between Onset and Death Months
	Medical Examiner		disease or condition resulting in death)		a consequence of):	t1a				+	Months
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					+	
	and -transit	Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	C. Due to (or on	a consequence of):						
0	ficate be executed g physician and as the burial-transit		resulting in death) Last	d.	a consequence or,						
09/89	certificate inding phy use as th	/Med	IF FEMALE:	000 16 1000 0140000							
. Box	death he atte ed for	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3 _	Ectopic pregnand Other (specify)	су		23d. Dat	te of delive nth I	ry Day Year
	s that the gned by the e detach	by Pr	Part II. Other significant conditi	ons contributing to death b	out not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use contr	ibute to the	e cause of death?
rds,	law requires nas been sign s 2 should be	eted									ably 4 🗆 Unknown
Yecc	has has	Completed		·				24a. Was a autops perform	med?	rvere autop prior to con death?	sy findings available inpletion of cause of
ta	iician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che		2 1 1 1 1	LI IES 2	2 LI NO
> tc	y Physi er this c eral dir	e: 10	1 ☐ Yes 2 X No 27. Manner of Death	1 Inpati		t 3 DOA Othe	4 LA Nursing F	lome 5 Reside			
0	tending leath. :or; Afte the fun	Certificate	1 Natural 5 ☐ Pendi 2 Accident Invest 3 ☐ Suicide 6 ☐ Could	igation	y, Year) injury	M 1 □	Yes 2 No				
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific Cycompleted filled in by the funeral director,		4 Homicide determ		ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (St City or Town		r or Rural F	Route Number,
	e Hospi 24 hou e Funer	Medical	(Check 2 \(\sumeq\) Medical	9 Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	xamination and/or investi	gation, in my opinio	on, death occurred	at the time, date an	d place, and due	to the caus	se(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifie		,	29c. License			9d. Date signed		
	D		30. Name and address of person	who completed course of d	eath (Itam 22a) (Time D	D4197	8		August 3	30, 20	012
	_		Nader Tavakol	i, MD 12200	Annapolis	Road, G1	en Dale,	MD. 2070	69		
	Stat Registra		31. Date filed (Month, Day, Year)	2012 3. Registra	ar's Signature	Ked.		 -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia E. Pheobus 25, 2012 8:57 p August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick St. Joseph's Ministries Emmitsburg If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Oct 9, 1949 Months Hours 1 M 2 X F Washington DC 62 220-54-2209 Director Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director Pikesville 1 Tes 2 No Maryland Baltimore 10f Zin Code 10e, Street and Number 10a. Citizen of What Country? Funeral 21208 USA 8805 Stone Ridge Circle #203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+ Warehousing 12 Executive Assistant other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last ပ Agnes Werlinger Kenneth Etter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Brierwood Blvd, Hanover, PA 17331 Kimberly Lowrie, daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of certain Creman Interplace) Date 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State any injury or Memorial Gardens 8/30/2012 Frederick, MD 4 Donation 5 Other (Specify) Myers-Durboraw Funeral Home 22. Name and Address of Facility Signature of Funeral Service Licenses 210 W Main St, Emmitsburg, MD 21727 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably been signature been signature been signature signature signature signature signature been signature been signature been signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signature signat Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy his certificate has t I director, page 2 s Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) rpleted filled in by the funeral 28a. Date of injury 28b. Time of 27. Manner of Deat 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗎 No Accident Investigation 3 Suiciae 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29d. Date stoned (Month Day, Year) 29b. Signature a ne and address of person who completed cause of death (Item 23a) Type

State Registrar 31 Date filed (Month.

Registrar's Signatur

5

mm

Funeral Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.

Physician Medical

Examiner

Baltimore, MD 21215-0036

Physician/ **Medical Examiner**

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

State Registrar

1

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

Director

To Be Completed by Funeral

F 01-4	St	ate of Maryla	and / L				and N	lenta	al Hy	giene		21	71	2 3	033
For State				Certific	ate of	Death				ł	Reg. No.	2 ()	د ک	000
Decedent's Name	(First, Middl	e,Last)								2. Date of De		V		3. Time of	f Death
DONNA LU	CILLE	PREUDHOM	ME							Month Septemb	er 13,	2012 Yea	ar	1218	hrs
		n, give street and nu			4	b. City, Town	n, or Loca	tion of	Death			: County			
18712 Capel	la Lane					Gaithers	burg					/lontgor	nery		
Social Security Nu	mber	6. Sex	7. Age (li	yrs. last birt	thday)	If Under 1		Under 2		8. Date of B	irth(MM	DD/YYYY			ate or
214-17-2	256	1 M 2 X F		25	Yrs.		Days	Hours	Min.	02/2	1 / 1 0	0.7	Foreig Co	in ^{untry)} MT	
ual Residence of D										02/2	1/19	0/	L	MI	,
a. State 1	0b. County		100	. City, Town	or Location	on								10d. Insid	e City Limit
MD	E d	1-	ŀ	Page de	3 - 1-									1 Ye	s 2 🗓 N
e. Street and Numl		<u>erick</u>		Frede	LICK	10f. Zip Co	de				10g. Citi	zen of Wh	nat Cour	ntry?	
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5615 Riv	vendel		- 11 5	-:	140.18/-	2170		- 0-1-1-	0 / 0	cify Yes or N	US		A	1	Disale
X Never Married	1 2 □M:	12. Was Dec		er in U.S.		s Decedent o es, specify C					0-		- Ameri e, etc.	can Indian,	васк,
		1 Yes	2 X	No											
Widowed		orced If Yes, Give Yes or Dates:		- B 140-		Yes 2X			1 - 6		1401	Specify:	Whi		
		cify only highest grad	-			s Usual Occ st of working					IOD, I	Kind of Bu	siness/i	naustry	
Elementary/Secon	dary (0-12)	College (*	-4 or 5+)												
Father's Name (F	inak 8 di alah a	4				stud			Na	First, Middle,	Maidan	0			
Bruce I		,								Pirst, Middle, Donald		Surname,)		
				400	L 14-:1:	A //							21.1	~ ~	
a. Informant's Nam				196						ural Route Nu		-			
Suzanne a. Method of Dispo		ldson/mot	her	20b, Place o	5615	River	<u>idel</u>	<u> Pla</u>	ce,	Frede					
Burial 2 X	_	3 Removal fr	om State		ory or oth		cemeter	y,		Date	20c.	Location -	City or	Town, Stat	е
Donation 5	_			Stauf	fer (Cremat	ory	lo:	9/1	7/2012	Fre	deri	ck,	MD	
Signature of Func					22. Na	ame and Add	ress of F			auffer					. A .
lu 4	./ /	1/1/	7							ike, F					
		complications that c	aused the	death. Do no										Approxir	nate Interv
failure. List only			. T.		40										n Onset and Death
mediate Cause (Fi condition resulting		a.Morphin			LION							_		-	
		b.												l	
quentially list cond ny, leading to imm		Due to (or as a	conseque	ence of):											
use. Enter Underly sease or injury tha		С.													
ents resulting in de		Due to (or as a	conseque	ence of):											
		_ d													
UNPENDED		AMENDED 2	23a,2	7,28a-	-1,pe	r me,	3931	9-2	5-1	2 sm					
EMALE:		23c. If yes,	outcome c	f pregnancy							230	d. Date of	delivery		
. Was decedent pr past 12 months?		I LIVE L		2	Feta	al death	3E	ctopic p	regnan	су		Month	D	ay	Year
Yes 2 No	g 🗸 Unk	noum		of death 5	5 Oth	er (Specify)					-				
		a 🗌 Olikii								100 5			b. 4. 5. 1		f 1" 0
rt II. Other signific	cant conditi	ons contributing to	death bu	t not resulting	g in the un	nderlying cau	se given	ın Part I	I.		_		-	he cause o	
										1Ye	s 2 _	No 3	Prob	ably 4 🗸	Unknown
										24a. Was					gs availabl
										auto	psy ormed?		nor to co leath?	ompletion o	n cause of
										1 Yes			✓ Ye		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi

25. Was case referred to medical	-	ALC: NO			26.Place	of Deat
examiner? 1 ✓ Yes 2 No	Hosp	oital: 1 Inpatient 2	2	ER/Outpatient 3	DOA	Other ₄
27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Inju	ry at Wo

rk? Natural 1 Yes 2 X No Pending fd 9-13-12 | fd 12:10pm Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide found in house determined

Z ACCIDENT	investigation		
3 Suicide 4 Homicide	6 X Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in house	28f. Location (Street and Number or Rural Route Number, City or Town, State) 18712 Capella Ln. Gaithersburg, MD.
torroom only		To the best of my knowledge, death occurred at the time, date and place, and	
one) 2 🗸		the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)

Yeth		roller	
30. Name and addre	ss of person who cou	mpleted cause of death (Item 2)	(a)

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

September 14, 2012

unknown

31. Date filed (Month, Day, Year, SEP 1 32. Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla State of Maryla		artment of Health tificate of Death			giene Reg. No. 201	2 30332
H	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Mamie Lee Everett Price				2. Date of De		3. Time of Death 1:16 a _M
1	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		<u> </u>	4c. County of D	
ال			Holy Cross Hospital		Silver Spr			Montgo	mery
	Funeral Director		5. Social Security Number 244-48-2996 Usual Residence of Decedent 7. Age (In yrs. 78) 1 □ M 2 ★ F	last birthday) Yrs.	If Under 1 Year If Under Months Days Hours		8. Date of Bir (Month, Da 10/24/	y, Year)	Birthplace (State or Foreign Country) NC
	yland f shov ed at	ţo		ity, Town or Lo					10d. Inside City Limits
	e Mar r 28a- notifie	Director	MD Montgomery Sil	ver Sp				w	1 🔀 Yes 2 🗌 No
	with th	Funeral I	8812 Lanier Dr. # 104		10f. Zip Code 20910			10g. Citizen of What USA	Country?
	leath items ier mu	Fun	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		Vas Decedent of Hispanic O f Yes, specify Cuban, Mexica	Origin? (Spec	city Yes or No-		merican Indian,
36	after or samir	d by	1 Never Married 2 Married 1 Yes 2 XNo		Yes 2 No Specif		rican, etc.)	Black, Will Specify: B1	_
9-0	hours natura sical E	lete	15. Decedent's Education	16a. Deced	lent's Usual Occupation			16b. Kind of Busine	
218	hin 72 ne. than " e Mec	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do	kind of work done during mo D NOT use retired) nsed Practi			Tarboro	
d 21	ed witi Hygiel other i	BeC	12th 17. Father's Name (First, Middle, Last)	Trice					7,110
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	户	Joe Everett		Fan	iners Name	Evere	<i>Maiden Suma</i> me)	
Mar	2 shoul th and th sum traums		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Numb Lanier Dr.	ber or Rural	Route Numbe	r, City or Town, State,	Zip Code) J. MD 20910
re,	1 and 2 s of Health item 27 other tra		Valerie Tripp/Daughter 20a. Method of Disposition 20b.	Place of Dispo	sition (Name of		ate	20c. Location - City	
imo	Page nent o ant: If ury or		- I - I - I - I - I - I - I - I - I - I		natory or other place) Lapel Cem	9/8/2	····	Tarboro,	
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee			ility Dic	kens	Funeral S	ervice 2788
	222.00	-	23a. Part 1. Enter the disease, or complications that caused the dea	P .	O.Box1428	3690F	reeniratory an	North Ta	rboro, NC
	hysician/		shock, or heart failure. List only one cause on each line.		l Infarctio		roopiiatory arr	031,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) ACUTE MYOC Due to (or as a consecutive form)		I amedicate				
		er	Sequentially list conditions, if any, leading to immediate		Disease				ļ
	rted J ansit	dical Examiner	cause. Enter Underlying Cause (Disease or injury	derice or,					
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687	certific nding I use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnant					23d. Date of o	Nalivan (
Box	death ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ XNo 1 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)		-	Month	Day Year
0	at the d by th detach		g Unknown Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause given in Par	rt 1	220 Did to	hassa usa santributa	to the cause of death?
Records, P.O. Box 687	ires th signe Id be o	d by	Malignant Hypertension						Probably 4 Unknown
ord	w requ	plete	Hyperlipidemia				24a. Was a		autopsy findings available
Bec	The la ate ha page	Completed	m, poz z z p z c c c c c c c c c c c c c c c				autop perfor	rmed? death	completion of cause of es 2 \sum No
ta	ician; certific rector,	Be	25. Was case referred to medical examiner? Hospital:		26. Place of De	eath (Check o			
Ž <	r this ceral dir	e: 10	27. Manner of Death 28a Date of injury	ER/Outpatient	DOA Other: 4 \(\sime\) N			ence 6 Other (Spe	ecify)
ono	ending sath. ir: Afte he fun	ficat	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work? M 1 □ Yes 2 □		a. Describe III	ow injury occurred	
Division of Vital	or Atter after de Directo in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	ome, farm, stre	et, factory, office	28	8f. Location (S City or Tow	treet and Number or F n, State)	dural Route Number,
ቯ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier 1 X Certifying Physician: To the best of my know	ledge, death o	ccurred at the time, date and	d place, and	I due to the ca	use(s) and manner as	stated.
	the Ho hin 24 the Fu npletel	Med	only one) 3 Certifying Nurse Practitioner: To the best of	n and/or investi	gation, in my opinion, death o death occurred at the time, d	accurred at th	ne time date ar	nd place and due to the	cause(s) and manner stated
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and title of certifier	MD	29c. License number D0061799		:	29d. Date signed (<i>Mor</i> 09/03/2	oth, Day, Year) 012
	ma		30. Name and address of person who completed cause of deam (Iten Gladys H. Lopez, MD 1500For		en Silver	Snrir	OG MD	20010	
	Stat		31. Date filed (Month, Day, Year) 7 2012 32. Figistrar's Signa	ture	all	Phili	rg, PiD	. 20910	
	Registra	ır	SEP U 12014 April	L. 4	·				

DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hygiene

2012 30333

Michael Anthony		sateri S I- For State	tate of M	arylan		rtment of <i>ificate</i> of			Mental Hy	ygiene		201	2 3033
Physicia		Registrar 1. Decedent's Name (First, Midd	lle.Last)		Cen	ilicate oi	Deali		 1	2. Date of De	Reg. No eath).	3. Time of Death
Medical Examin		MICHAEL ANTHON		ггот						Month August 2	5, Day	Year 12	1443 hrs
3	ı	4a. Facility Name (if not instituti	on, give street	and numb	per)	1	4b. City, To	wn, or Lo	cation of Death			c. County of Dea	ath
		Severn Grove Marina	near 197	Severn	Dr		Annap	olis		Anne Arui			
Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. las	st birthday)	If Under Months		If Under 24Hrs. Hours Min.	-		1/DD/YYYY) 9. E Fore	Birthplace (State or eign
Director		047-62-1116	1 <u>X</u> M 2	F	53	Yrs		Days	Tiodis Willi.	2/3/1	959	M	ASSACHUSETTS
A.	F	Usual Residence of Decedent 10a, State 10b, County			Inc City 7	Town or Locati	ion						10d, Inside City Limits
ow any	i	ANNIE	ARUNDE]		ANNAI								1 Yes 2 X No
Maryland 28a-f show datonce.	핡	MARYLAND ANNE 10e. Street and Number	AKUNDE		ANNA	ODID	10f. Zip (Code			10g. Cit	tizen of What Co	
or 28	Director	1801 SHORE DRI	WE.				2140	1			IINT	TED STAT	res
with t		11. Marital Status	12. W		lent Ever in U.S		s Deceden	t of Hispa	inic Origin? (Sp			14. Race - Ame	erican Indian, Black,
death r	uneral	1 Never Married 2 X	larried A	med Forc	es?	If Y			Mexican, Puerto	Rican, etc.)		White, etc.	
after o	S.	3 Widowed 4 Di	vorced If Yes,	Give Year		1		No :				Specif.	HITE
hours natur Exam		15. Decedent's Education (Spe							n (Give kind of w O NOT use retir		16b.	Kind of Busines	s/Industry
36 in 72 han "	Bet	Elementary/Secondary (0-12)	Co	llege (1-4 5+		rravet.	TNDUS	STRY	EXECUTI	TVE.		TRAVEL	
d with	Completed	17. Father's Name (First, Middle	, Last)						.Mother's Name				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	FRANK PUSATER	T SR.						HELEN S	SAVINO			
21, ould b d Men	٥	19a. Informant's Name/Relation	ship (Type, Pr	int)		19b. Mailing	Address	(Street a	and Number or R	Rural Route No	umber, C	City or Town, Sta	ite, Zip Code)
MD id 2 shoulth and m 27 is		KATHLEEN L. RO	BERTS/	JIFE					/E ANNAI			21401 Location - City	Town Chair
or Hea		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Rer	noval from		ace of Dispos ematory or oth SAPEAKT			INC	Date			·
Page ment tant:		4 Donation 5 Other S			ČEÑ	rer			8/28	3/2012			ILLE, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	21. Signature of Funeral Service Licenses 22. Name and Address of Facility LASTING TRIBUTES HELFENBEIN & NEW AM CREMATION 8 814 BESTGATE ROAD ANNAPOLIS, MD											he fin	EFAL CARE
Physician	- 1	23a. Part. Enter the disease, o	r complication	s that caus	sed the death. I	1814 Do not enter th	+ BES.	TGAT1 dying, su	L KUAD A	NNAPUL r respiratory a	rrest, sh	nock, or heart	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line.		hanging								Between Onset and Death
Examiner	-	or condition resulting in death)			onsequence of)	:							
		Sequentially list conditions,	b	,									-
- mar	흺	if any, leading to immediate cause. Enter Underlying Cause		or as a co	onsequence of)								
p is	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
f 0, e be executed ysician and burial - transit	d. UNPENDED AMENDED												
OX (8760, ath critificate be execut attenting physician and for use as the burial - tra	edical	IF FEMALE:	1,77	-	tcome of pregna						22	3d. Date of delive	20/
68761 certificate reing phy	ician/M	23b. Was decedent pregnant in to past 12 months?		Live birth			tal death	3	Ectopic pregna	ncy	120	Month	Day Year
Box (e death centre attended for use	10		known 4	_	t at time of dea	th 5 Otl	her (Specia	fy)					
the de	ΞL	Part II. Other significant condi	19	Unknow	2000	sultina in the u	underlying o	ause give	en in Part I.	23e. Did	tobacco	use contribute (to the cause of death?
F.O.	2			J		G	, ,			1 🗆 Y	es 2	✓ No 3 Pr	obably 4 Unknown
ords, w require ts been si should b	Completed									24a. Wa			autopsy findings available
Cords	힡									perf	opsy formed?	death?	
tal Rec		25. Was case referred to medical	al T		 		26	S.Place of	Death (Check of		2 🗸	No 1	Yes 2 No
Vital I hysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	Hospital	1 inp	atient 2 E	ER/Outpatient		104			Resid	lence 6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a second to be a	H١	27. Manner of Death	28	a. Date of OUND:		28b. Time of li	njury 28	Bc. Injury		28d. Describe Subject ha			
ion of tending Pteath. tor: After to the funeral	랿		aina I	OUND: ug 25, 20	I .	FOUND: 1443 hrs		1 Yes	2 ✔ No				
Divisipital or At ours after d	Certification:	3 Suicide 6 Cou	ild not be 28		of Injury - At hor	ne, farm, stree	et, factory,	office buil		or Town,	State)		Rural Route Number, City
Daspital hours meral y filler	8	4 Homicide		pecify)									evern Dr, Annapolis, M
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death critificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attenting phy completely filled in by the funeral director, page 2 should be detached for use as the tentile of the funeral director, page 2 should be detached for use as the tentile of the funeral director.	Medical	(Check only Gertifying r	aminer: On the	basis of	examination an							nd manner as sta lace, and due to	
To To	¥	29b. Signature and title of certifi		anner stat	ed.	1	29c.	License r	number		29d.	. Date signed (M	fonth, Day, Year)
		Calsi	1 1	1	1/1	/	į	O.C.M.	E.		Aug	gust 26, 201	2
15	ŀ	30. Name and address of person				-	1						
W							Baltimore	Street	, Baltimore,	MD 21223			
Sta Registi	-	31. Date filed (Month, Day, Year AUG 28	2012	32/Regis	strar's Signatur	ber	Les I						
rtegisti	للته	NOU NO		A ALEX		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 21 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fredorick If Under 1 Year If Under 24 Hrs. Assisted Living Frederick I rangual, Social Security Number 7. Age (In yrs. last birthday, 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days Min (Month, Day, Year) 203-01-6103 Director 92 May 30, 1920 Usual Residence of Deced Pennsylvania 28a-f shov 10a State 10b County 10c. City, Town or Location the Merylend treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Frederick 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 236 within 72 hours after death with 6441 Jefferson Pike, Apt. 223 21703 USA or items 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: White "neturel", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 end 2 should be filed within 72 nent of Health and Mental Hygiene. ent: if item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William C. Sharpe Mida McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith M. Schmidt/Daughter Sovereign Place. Frederick MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State Department of H Importent: If ite any Injury or ot once. ARLINGTON NATIONAL CEMETERY 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington, VA Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician R rKinsons Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day

or Attending Physicien: The law requires that the death certificate be executed To the Hospital or Attending Physicien: The law requires thet the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-basis. Division of Vital Records, P.O. Box 68760

1 ∐ Yes 2 No 9 ☐ Unknown	9 Unknown	death 3 Dome (specify)								
Part II. Other significant conditions of	contributing to death but not re-	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death?						
				24a. Was an autopsy performed? 1 🗆 Yes 2 🔀 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 🗆 Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 I	OOA Other: 4 Nursing H	lome 5 ☐ Residence 6	Other (Specify) ASS Stal Lug.						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur							
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	280 Place of Injury - At h		ry, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)						
29a. Certifier 1 Certifying Phy	sician: To the best of my know	ledge, death occurred	at the time, date and place.	and due to the cause(s) a	nd manner as stated						

(Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the hest of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as state. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Va

30. Name and address of pers who completed cause of death (Item 23a) (Type, Print)

Mel. 126 31. Date filed (Month, Day, y, Year) 06

State Registrar

10

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30335 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Thomas 9:23 John Perkoski 2012 September Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3330 N. Leisure World Blvd.. #223 Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 208-16-9618 87 Director 1 X M 2 □ F May 19, 1925 Pennsylvania Usual Residence of Dece th and Mental Hygiene. ?? Is marked other then "natural", or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3330 N. Leisure World Blvd., #223 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1943-46 ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: speciaWhite 3 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life, DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Police Officer Law Enforcement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 9 John A. Perkoski Stella Verbinski 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Frances L. Perkoski/Wife 3330 N. Leisure World Blvd., #223, Silver Spring, MD injury or other tem 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot Sept. 1 2012 1 Burial 2 Cremation 3 Removal from State 10, 4 ☐ Donation 5 ☑ Other (Specify)entombment Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Convective Heart Failure vrs Medical Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ed by the attending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

To Be Completed by Physician/Medical Certificate:

Medical

Suicide

29a. Certifier

(Check

only one) 29b. Signature

Naku1

and tit

31. Date filed (Month, Day, Year) SEP 0 5 2012

Goyal MD

30. Name and address of perso

Investigation 6 Could not be

resulting in death)	a. Competitive means ratifal									
resulting in death)	Due to (or as a consequence of):									
Sequentially list conditions,	Ischemic Cardiomyopathy			yrs						
If any, leading to immediate	Diss to (or as a donesiquence of):									
cause. Enter Underlying Cause (Disease or injury										
that initiated events resulting in death) Last	Due to (or as a consequence of):									
,										
	d	· · · · · · · · · · · · · · · · · · ·								
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		23d. Date of de	livery						
in the past 12 months?										
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown									
Part II Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacco	use contribute to	the cause of death?						
Hypertension, Ve	ntricular Tachycardia	1 ∐ Yes	2 ∐ No 3 ∐ F	Probably 413 Unknown						
		24a. Was an	24b. Were au	topsy findings available						
		autopsy performed?	death?	completion of cause of						
		1 ☐ Yes 2 🖾		s 2 🗆 No						
25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)								
1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 🖾 Residence	6 ☐ Other (Spe	cify)						
27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28c	d. Describe how inju	ury occurred							
1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Day, Year) injury work? M 1 □ Yes 2 □ No									

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#211

3801 International Drive, Silver Spring, MD 20906

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) September 4, 2012

DHMH 17 Rev 06-2011

State

Registrar

12+

acted

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 30336 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Emilia Padilla 3:30 A.M September 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Security Number . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 01/17/1955 Country) El Salvador Director 1 🗆 M 2 💢 F 579-04-5186 57 Yrs Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Montgomery MD Silver Spring 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 12308 Goodhill Road 20902 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 White 1 X Yes 2 No Specify: Salvadorian If Yes Give 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Italian Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Rogelia Nolasco Iginio Garmendez 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12308 Goodhill Road, Silver Spring, MD 20902 Nicolas Padilla (Spouse) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) September Gate of Heaven Cemetery 2012 Silver Spring, MD . Signature of Funeral Service Licknise 22. Name and Address of Facility DeVol Funeral 1 Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 1 RACY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): ш resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No ò Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peritonitis Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an Anoxic Encephalopathy has autopsy performed? Yes 2 X No certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No Be 26. Place of Death (Check only one) Hospital: 2 💢 No 1 😾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) September 3, 2012 D0063343 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Trina Kuban M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 State Registrar

			Please	State of M.	nt in B	Black In	delible	of H	. Ensure	All Copies Mental Hyd	s Are Le	gible.	30337
		-	For State Registrar	Otate of W	ai yiai ic		tificate				Reg. No.		
	Physicia Medio		1. Decedent's Name (First, Middle, La. Ruby E. Peach	n						2. Date of Dea	29 ^{ay} , 2	01 ² 2 ^{ar}	3. Time of Death 11:30 Рм
)	Examin		4a. Facility Name (if not institution, give				4b. City, To		Location of Deatle	n	4c. Cour	ity of Death \mathbf{Fr}	ederick
	Funeral Director		5. Social Security Number 6. S 578-34-9366	Sex 7. Ag	e (In yrs. las	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.		y, Year)	Cou	nplace (State or Foreign ntry) hington, DC
	and show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation	J					10d. Inside City Limits
	e Maryl r 28a-f notifie	Direc	Maryland Freder	ick			10f. Zip (lerick		10g. Citizen	of What Cou	1 🗆 Yes 2 🔁 No
	s 23a o sust be	Funeral Director	10726 Liberty Ro	ad				217	01		Tog. Onizon	USA	-
356	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show ked other the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 24 If Yes, Give Year or Dates.	Ever in U.S. No	- 11	Vas Deceder Yes, specif	y Cubar	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		lack, White	ican Indian, , etc. White
<u>2</u> -0	2 hours "natur edical l	Completed	15. Decedent's E (Specify only highest gi	Education			kind of work	done di	ation uring most of wo	rking	16b. Kind of	Business/l	ndustry
212	within 7 giene. er than , the M		Elementary/Secondary (0-12)	College (1-4 or s	5+)		o & V		l Assis	tant	Board	of E	ducation
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last) George Mire			_			18. Mother's Na	me (First, Middle, Oncay	Maiden Surna	me) 	<u> </u>
Mar	sh har 7 Is trau		19a. Informant's Name/Relationship (Stephen Peach /			l				_{iral Route Numbe} Frederic			Code)
	e 1 and 2 soft Health of Health If Item 27 or other tr		20a. Method of Disposition 1 Burial 2 XCremation 3		ce	ace of Dispo	sition (Name	e of her olace	9)	Date	20c. Locatio	n - City or	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		4 ☐ Donation 5 ☐ Other (Spec 21. Signatur of Funeral Service Licer	ify)	St				ory 9/4				, Maryland
Ba	permit. Departri Importa any injt		1 /outness	Stault	u_	280	1621	Орс	ssumtow			ick, l	MD 21702
	nysician/		23a. Part 1. Enter the disease or con shock, or heart failure dist only Immediate Cause (Final disease or condition	nplications that dauser one cause on bach lin	d the death. e.	Do not ente	er the mode	of dying	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death SyA5
7	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of): ハン ロ	15C1	las	- Dis	sease.			10 1/15
*	sit.	Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury	b. Jule to (or as	s-ruir səqlik	moseuffr ~ Allo	L x /	0	10	· lac D	4 SAA C	D	75445
	executed an and irial-transit		that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	TIL C	anu	<u>no vuo c</u>	ww 6	المالية		23 4363
092		edica		d									
Box 687	e death certificate be the attending physicia hed for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▶ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pr Other (spe		у			Date of deli Month	ivery Day Year
, P.O.	requires that the dea been signed by the should be detached	è	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the u	inderlying ca	ause giv	ren in Part I.	23e. Did t			the cause of death?
Records,	w requii s been 2 should	Completed								24a. Was		prior to d	copsy findings available completion of cause of
Rec	nysician: The law nis certificate has b I director, page 2 s		OF Mrs and a modical					00. 51	(0)	perfo	ormed? 2 X No	death? 1 Yes	2 🗆 No
Vital	Physician this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 E	ER/Outpatier	nt 3 🗆 DO	Otho	ace of Death <i>(Che</i> er: 4X Nursing	Home 5 Resi	dence 6 🗆 0	other (Spec	(fy)
n of	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	ury y, Year)	28b. Time of injury	т 28 м	Bc. Injury work 1 🗀		28d. Describe	how injury occ	urred	
Division of Vital	ten for:	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Ini						28f. Location (City or Tou		mber or Rui	ral Route Number,
	e Hospital or At n 24 hours after o e Funeral Direct bletely filled in by	Medical	(Check 2 Medical Exar	ysician: To the best of niner: On the basis of arse Practitioner: To the	examination	and/or inves	tigation, in m	y opinic	n, death occurred	l at the time, date a	and place, and	due to the o	cause(s) and manner state
	To the I within 2 To the I comple	-	29b. Signature and title of certifier	P He	an	CRN	* ~		e number	7	29d. Date sig	- 1	
	か		30. Name and address of person who			23a) (Type, F	Print)	سلہ	nister	MD	フルビー	· · · · · · · · · · · · · · · · · · ·	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signati	ure .	barke		TING TO	1-10	2113		
	Registr	ar	SEP UD	CUIC ABOUT	and of	f3. pla	CARLA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lola Mae Parks Sept P 6:27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Health Care Center Solomons Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/04/2008 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Min **Director** 1 □ M 2 🕱 F 572-03-7308 104 Nebraska 1 and 2 should be Nied within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Calvert Maryland Solomons 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 11450 Asbury Circle 20688 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 X No Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Director of Pupil Services Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Dora Eta Killen Arthur Henry Hughes 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Hurt 8273 FM 603 Clyde Texas 79510 niece 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMCCemeteyr Sept 10 2012 Lusby Maryland 22. Name and Address of Facility Rausch Funeral Rome 21. Signature of Fune al Service License, 1aus 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Steo ma 2 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s certificate has director, page 2 perforn 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completely f Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, September 4, 2012 25156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Bennett, MD HG Trueman Road Lusby, MD 20657

aku D

State Registrar 31. Date filed (Month, Day, Year) 32. Registry's Signature

B. Sarles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mou**p**8/55/50**7**5 AVERY V. PATTERSON 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4158 Silver Park Terrace Prince George's Suitland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Min Hours 237-02-9674 Director 1 🗆 M 2 🗶 F 04/09/1956 NC Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4158 Silver Park Terrace 20746 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Analyst State Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Louise Lockhart Edward Lee Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4158 Sliver Park Ter., Suitland, MD 20746 Andrew Patterson / husband other 1 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State Clinton, MD Resurrection Cemetery 08/28/2012 4 Dopatton 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services Funeral Se 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 years ung ance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death signed by the q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an neral birector: After this certificate has filled in by the funeral director, page 2. autopsy performed? 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.

15 M

29a. Certifier

(Check

only one)

3

been ous

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

110 Irving Street, NW GBIO Washington OC Charlotta Dean, Mp Month, Day, Year) 2. Registrar's Signa State

Registrar

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D47654

29d. Date signed (Month, Day, Year)

22,2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 2,2012 Physician/ Johnson Powe11 Gladys September 7:15 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) 1927 Days Hours Min. 229-22-1502 85 Director August 13. Virginia Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No District of Columbia Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20012 1805 Tulip Street, N. W. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S.Dept. of Housing (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Merital Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mg Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Administrative Clerk Urban Development å 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Gertrude Carter Johnson Wilmer R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Tulip Street, N.W.; Washington, D.C. 20012 Diane Elaine Baxter (Niece) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rock Creek Cemetery Sept.12,2012 Washington, D.C. 4 Donation 5 Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Faneral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 M01421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Malignant Pleural Effusion Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Terminal Lung Cancer Sequentially list conditions, Examine any, leading to infriediate cause. Enter Underlying Cause (Disease or injury Dusto (or as a our sequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown g X Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dia 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City. or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one nd title of certifier 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) D0067279 September 2, 2012

SM

Registrar

State

31. Date filed (Month, Day, Year)

SEP 0

6 2012

of person who completed cause of death (Item 23a) (Type, Print) Holy Cross HOspital

32. Registrar's Signature

Alagarsamy Verrappan, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Month Physician/ 2012 VICKI LYNN RICHEY 9:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign July 23, 1949 Director 215-58-9219 63 1 🗆 M 2 💢 F Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 7888 West Hills Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ۵ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: 3 ☐ Widowed 4 🎗 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 end 2 should be filed with of Heelth end Mental Hygien Item 27 is marked other the Insurance Processor Federal Governmen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ရ Carl Leizear Betty Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cory Richey / Son 6416 Towncrest Terrace, Frederick, Maryland 21703 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September permit. Page 1 Depertment of I Important: If It 1 Burial 2 D Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 6, 2012 Smithsburg, Maryland 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home, J. MO1473 Church Street. Frederick. Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Meta storic

Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ettending physician and I for use es the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physicien: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gettiying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number Hiren NohoL

DHMH 17 Rev 06-2011

19

Registrar

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10b-c, 10e-f, per INF, e931 9-26-12 sm. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012^{ea} September Louis Carl Riecks, Sr. 8:59 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Morningside House Waldorf If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days Months Hours (Month, Day, Year) **Director** 577-62-7481 1**XX**M 2 □ F 64 Jan. 16, 1948 Washington, DC Usual Residence of Decedent 23a or 28a-f show with the Maryland Examiner must be notified at . City, Town or Location **Deale** 10d. Inside City Limits Funeral Director Anne Arundel 1 Yes 2XXNo Maryland Prince Georges Brandywine 10e. Street and Number 848 Mason Ave. 10f. Zip Code **1** 10g. Citizen of What Country? 4820 Blueberry Dr. U.S.A 20613 "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 XX Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Repair Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Phillip Riecks Dorothy Louise Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4820 Blueberry Dr. Brandywine, MD 20613 Kimberly D. Gallegos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September 7, 2012 Resurrection Clinton, MD 21. Signature of Funeral Service Licen MO1555 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any leadin; to immediate cause. Enter Underlying Physician/Medical Examiner Due to or as Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a physician or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Yes 2 No should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy death? performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page. 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year,

State Registrar Name and address of bers

31. Date filed (Month, Day, Year)

race

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WAlder

20602

who completed cause of death (Item 23a) (Type, Print)

old line

Registrar's Signature

12070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANCES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin Inpatient Care Center Harwood Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 217-50-8119 1 M 2 X F 09/24/1947 Maryland 64 Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 No Annapolis Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21403 2104 Chesapeake Harbor Dr. E.Unit 102 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Š 1 Never Married 2 Married 72 hours after Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ruby Monroe Sylvester Victor Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 st ment of Health a ant: If item 27 is 614 Federal Oak Dr., Sunderland, MD 20689 Pam Shilling/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 08/27/2012 Edgewater, MD Kalas Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home Solomons Island Rd.. Edgewater. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Paset and Prati Immediate Cause (Final Physician/ ase or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): After this certificate has been signed by the attending physician and strueral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ other (Specify) CARE CTR Other: 4 Nursing Home 5 Residence 2 NO ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funerel Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month

441 DEFENSE

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print) (ENTA M

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	rieas					d / Dep		t of H	lealth		Mental Hy	giene	•	ible.	30	31.1.			
Physician Medic		1. Decedent's Name Daphne E	(First, Middle, I Elaine I	ast) Russe	e11								2. Date of De Month	Reg. No	ay	Year	3. Time of Zo	of Death			
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Funeral Director		5. Social Security Number 007-20-3564 6. Sex 1 M 2 MF 85						If Under 1 Year If Under 24 Hrs. 8. Date of E (Months, to 04/12)					y, Year)	7	Countr	y)	or Foreign				
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.						Was Deced If Yes, spec 1 Yes	ify Cubar	spanic Ori n, Mexical Specify	n, Puerto	cify Yes or No- Rican, etc.)		14. Race Black Specify:	- America k, White, et	Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social So					
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uld be filed Mental Hy aarked ott aatic even	To Be	17. Father's Name (First, Middle, Last) Vernon Clement											e (First, Middle, F1ewe11								
and 2 shou Health and em 27 is n ther traum		19a. Informant's Name/Relationship (Type, Print) Brenda Werner Daughter 19b. Mailing Address (Street and Number or, Rural Route, Number, City or Jown, S 10504 Cassandra Drive, Chance, Md.												;-Zip 60de)							
it. Page 1 rtment of I rtant: If it njury or of		20a. Method of Dispo 1 Burial 2 4 4 Donation	Cremation 3	ecify)	oval from	State	Sa ²	ace of Disponentery, cre	y Cre	mato:		8-3	Date 27-2012	S	alish	oury l					
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2 \$ 2 8		29b. Signature and ti		àf.	YASH	IVIR	SA M.	D D	290	License	number 74	3		29d. Da	te signed	(Month, De	y, Year)	2			
3		30. Name and addres	SANG		eted cause	e of deat	h (Item :	23a) (Type, 100 €.	Carl	eocz	5-	_5 _A	LISBU	ey.	Md	- 21	801				
State Registra	S	31. Date filed (Month)	AUG 2	201	32. Re	gistrar's	Signatu	Jre	bare			-50									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 21:24 ARLYCE STAMPS ROBINSON 1,2012 September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Montgomery Gaithersburg 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 577-48-2115 Director 1 🗆 M 2 🔀 Washington,DC 10/14/1934 item 27 is marked other than "natural", or items 23a or 28a-f shov other treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Germantown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13115 Millhaven Place 20874 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Nidowed 4 Divorced American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Computer Sciences College (1-4 or 5+) Elementary/Secondary (0-12) Office Coordinator Corporation permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe eny injury or other treums***: Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Stamps Alice Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia T. Ashley/Daughter 14257 Oxford Drive, Laurel, MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 09/07/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Acute Myocardial disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner oronary av ears Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physicien: The law requires that the deeth certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) م| 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 IDOA hin 24 hours after death.

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mpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 37024 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Srour 9901 Medical Center Drive Rockville MD 20850 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2012 September 4:00 A M Elizabeth Ross 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Village at Rockville Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Min. (Month, Day, Year) Director 577-28-7815 1 🗆 M 2 🖾 F 89 04/03/1923 Pennsylvania in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21000 Father Hurley Blvd. 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ai Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Accountant Finance Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be flied nt of Health and Mentai H I: If item 27 is marked ot ည Tambourine Antonio Marietta Tamburrino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Antonelli/Daughter 13604 Monarch Vista Drive, Germantown, MD. 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it any Injury or or Page . 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 109/08/2012 | Silver Spring, MD. 22. Name and Address of Facility DeVol Funeral Home Signature of Fungral Services 10 East Deer Park Dr., Gaithersburg, MD. 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final FIBRUSIS Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Tha law requires that the death certificate ba executed ng physician and as tha buriai-trapsit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ å 1 Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy After this certificate 1 ☐ Yes 2 ☑ No Yes 2 N To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier D0064624 September 1,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDEEP SITARMA 2701 Velica 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

SEP 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month V9US Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Himore The Johns took tospita Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Months Hours Min. 089-30-5023 73 Director 1 M 2 X Sept.8,1938 New York or 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Potomac 1 Yes 2X No Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 USA 9417 Sunnyfield Court 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give δ 1 Never Married 2 A Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary/Administrator Business Development æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ William Warren Annabelle Conroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau 9417 Sunnyfield Ct., Potomac, Md. 20854 Lawrence B. Ryan/Husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sept. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Va 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home M00215 PMy 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Luna cancer Physician/ disease or condition resulting in death) Medical Due to tras a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): B Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injur) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to c death? 1 A Yes After this certificate 2 🗆 No 2 🗆 N Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ A Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

only one)

29b. Signature and title of certifie

30. Name and address of person

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31. Date filed (Month, Day, Year) SEP 0 4

Registrar DHMH 17 Rev 06-2011

State

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M.D

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

orleans Street Baltimore, Md

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1 201 Christine Barbara Renten Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 74 Director 442-34-7885 1 □ M 2 🗓 F 10/1/1937 Kansas Usual Residence of Deced 28e-f show 10a. State 10b. County 10c. City, Town or Location or than "netural", or items 23a or 28e-f sho 10d. Inside City Limits Director Texas Galveston Galveston 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4115 Avenue T. 77550 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Il Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Programmer Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ၉ Myron Oak Lillian Drugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If item 27 Is eny injury or other trau Paula Renten / daughter 3047 Chickweed Place, Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Stauffer Crematory 9/5/2012 4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. - garpulula 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician (andida) disease or condition resulting in death) Medical Examiner Adeno carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine (or as a consequence of) physiclan and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending ph IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 Unknown Pregnant at time of death Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I Completed 1 → Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNo 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijaction in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) September 1, 2012 DOO 73197

State Registrar 400 West 7th St. Frederick, manyland 21701

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

. KUY MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Anna A. Rimmer 5:45 August АМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Nursing Home Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 31 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F 94 218-03-6278 Director Dawsonville, MD Usual Residence of Decedent 28a-f show Ji Hygiene. other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's University Park 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4219 Van Buren Street 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14, Race - American Indian Armed Force Yes 2 X No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Edwin Ruthvin Allnutt Carrie Williams and is m 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh nt of Health a : If item 27 is Harry E. Rimmer / Son 180 Bunny Lane, Palmyra, PA 17078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 8/31/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months for Month the 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed iis certificate has been si director, page 2 should l 24a. Was an Were autopsy findings available prior to completion of death? perform To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury ☐ Accider ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

MYM

State Registrar

SANDERP SHARMA 31. Date filed (Month, Day, Year) AUG 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifier

> 9701 . Registrar's Signa

3a) (Type, Print)
Veis Dr. Rockville, MD

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day Month Year Riger 23:52M tottlemye 2012 Medical 4a. Facility Name (if not institution, give street and number) medical Examiner 4b. City, Town, or Location of Death 4c. County of Death niversity of Mar lan Baltimare Center Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days 216-92-6556 **Director** 1 🗙 M 2 🗆 F 40 July 21, 1972 Maryland 28a-f shov the Maryland 10c. City, Town or Location Director notified Carroll Taneytown Maryland 1 Yes 2 No 10e. Street and Number r items 23a or iner must be r ö 10f. Zip Code 10q. Citizen of What Country? by Funeral 21787 3643 Baptist Road USA and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Excavating/Construction Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ပ Roger W. Stottlemyer Patricia Miller traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Patricia Long, mother 3643 Baptist Road, Taneytown, MD 21787 or other 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cePitmeyem@neekner place) 8/30/2012 Taneytown, MD Brethren Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home intain 136 E Baltimore St, Taneytown, MD 21787 3a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. ARDS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner emo phagocytic syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Lymphone use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b , page 2 autopsy 1 Yes 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

of the

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S. Greene St. Baltimore

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG 2 8 2012

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . Month eptember 0007 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HOPKINS HOSPITA 7. Age (In yrs. last birthday) ar If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 578-13-4373 (Month, Day, Year) Hours Min. 32 Wash, Director 1 □ M 2 🛣 F 8-22-1980 D.C. Pege 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

tent: If tem 27 is marked other then "neturel", or items 23e or 28e-f show jury or other traumatic event, the Medical Eventine: must be notified et 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD PG Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13003 Crocker Place 20774 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Alvin M. Saunders Charlotte Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Price (Mother) 13003 Crocker Pl. Upper Marlboro MD.20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Cem cemetery, crematory or other place) permit. Pege 1 a
Department of H
Importent: If Ite
eny Injury or oti 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9-12-12 Hyattville MD. 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem"l 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licen Hun CC353 908 Kennedy St. N.W. Wash, D.C. rancy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events nei Due to (or as a consequence of): Exam To the Hospital or Attending Physicien: The lew requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ No 9 ☑ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗹 No 3 🗍 Probably 4 🔲 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 1 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie RES-000 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lavor 1800 N. Orleans St. Baltimore MD Sa 31. Date filed (Month, Day, Year) State 32. Registrar's Signature area Registrar

Amend #1 per P			e Type or Pı							-		_	le.		
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Baltimore, bernit. Page 1 and bepartment of Hee mportant: If item iny injury or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		e C	lace of Dispo emetery, cren rylan	natory or otl	ner plac		0: 8=24	ate -12		ocation - Cit OWNSV	· .	n, State e, Md.	
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Medical Examiner		resulting in death)	a. Due to (or a	s a consequ	_										
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041341		30. Name and address of person wh	completed cause of	death (Item	23a) (Type, F	D'FF	ENS	EH	Wa	AN	NA	9045	MI	14012	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30353 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Nancy Christenson September 5:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Spring House Assisted Living Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director 92 350-18-1029 1 □ M 2 🗓 F Dec. 10, 1919 TT. Usual Residence of Decede item 27 is marked other then "netural", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 ☐ Yes 2 No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 USA 9502 Culver Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent 1944 Armed Forces? 1944 1 ☑ Yes 2 ☐ No 1947 14. Race - American Indian, Black White etc should be filed within 72 hours after of and Mental Hygiene.
Is marked other then "netural", or δ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hester Norman George Christenson 1 and 2 should be of Health and Meritem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 Eastwood Avenue, Janesville, WI 53545 Robert L. Douglas/ Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1XXBurial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sep. 12, 2012 Whitewater, WI Hillside Cemetery 21. Signature of Funeral Service Licenses 72. Name and Address of Facility. Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician end burial transit Exam thet the death certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physiclan/Medical _d Hypertension Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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9 ☐ Unknown 5 Other (specify) Month Dav Year is certificate has been signed by the idirector, page 2 should be deteched 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physicien: The law requires t within 24 hours after death.
To the Funcerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X N 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Assisted Living 1 ☐ Yes 2 🛣 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 0 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural Certificat 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 20 D67092 September 5, 2012 #130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weihan Wang, MD 15245 Shady Grove Road, Rockville, MD 20850 31. Date filed (Month, Day, Year) State SEP 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leo Sullivan 6:40 p M 2012 Medical September 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Arcola Health And Rehab. Center Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 91 **Director** 024-12-8778 1 🏻 M 2 🗆 F March 31, 1921 Usual Residence of Decede -1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Silver Montgomery Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 Sisson Court 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 Never Mamied 2 Married ò Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CEO Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Sullivan Anne Feeney permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Sullivan/Son 5308 Westpath Way, Bethesda, MD 20816 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Sept. 6, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 <u>Alexandria, VA</u> 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebrovascular Accident Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Who the Funeral Director After this certificate has been signed by the attending named accompletely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in by the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely filled in the funeral director named to be a completely f Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0064624 reep September 5,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDER SHARMA 9701 Veirs Dr Rockville, MD 20850 Veirs Dr.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

SEP 0 6 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death JOYCE MAY SAMPSON Physician/ Month 19:28p M 8729 2012 Medical 4a. Facility Name (if not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center Olney Montgamery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Hours Min Days **Director** 1 □ M 2 F 577-78-0631 80 6/12/1932 JAMAICA Usual Residence of Dece 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14514 Homerest Road, 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ŏ by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3X Widowed 4 Divorced Specify. Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) Bila 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Bilah Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Assistant-Nursing Organic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leopold Williams Mabel Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Donna Tucker/daughter 32 Scarlet Sage Ct., Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department of Important: If it any injury or o ó 9/4/2012 Silver Spring, MD Donation 5 Other (Specify) Gate of Heaven Funeral Serv 21. Sign 🛬 22. Name and Address of Facility Snowden Funeral Home Licensee MO1576 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ATHEROSCLEROTIC CARDIOVASCHLAR disease or condition resulting in death) 124R Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to minimistrate cause. Enter Underlying Cause (Disease or injury Examine Directs for delaled normanite of: and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical nq The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Month Dav Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed neec Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 Yes 2 No page 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital Other: 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this qompletely filled in by the funeral or 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) No iniury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

DHMH 17 Rev 06-2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERRING MO

18101

Registrar's Signature

PRINCE

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	le of Maryland		tificate of L		•	Reg. No.20	12 30356			
I	Physicia	n/	1. Decedent's Name (First, Middle, Last)				_	2. Date of Dea Month	ith	3. Time of Death			
4	Medic	al	RIC 4a. Facility Name (if not institution, give street and		NDERH		COTT	Augus	<u>t 20 20</u>	012 2:29 A ^M			
	Examin	er	Frederick Memoria	,	al	4b. City, Town, or Frede		III	4c. County o	lerick			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h	Birthplace (State or Foreign Country)			
	Director		375−20−1976 1 X M 2 D Usual Residence of Decedent	□ F 88	Yrs.	World's Days	Hours Will.	Jan.24		New York			
	and Show Lat	or	10a. State 10b. County	10c. City,	, Town or Loc	cation		-		10d. Inside City Limits			
	Maryla 28a-f	Director	Maryland Frederick	A	damsto	wn				1 ☐ Yes 2 🔀 No			
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		10e. Street and Number			10f. Zip Code	21710		10g. Citizen of W	hat Country?			
	ath wi	Funeral	3369 Upland Court 11. Marital Status 12. Was	Decedent Ever in U.S.	13 V			pecify Yes or No-		- American Indian,			
ဖွ	ter de , or ite	by F	Arme	ed Forces? Yes 2 No s, Give		Vas Decedent of Hi Yes, specify Cuba		to Rican, etc.)		, White, etc.			
8	urs af tural", al Exa		3 Widowed 4 Divorced Year	s, Give or Dates. WWII	1	Yes 2 XNo	Specify:		Specify:	White			
5	72 ho n "nat	Completed	15. Decedent's Education (Specify only highest grade compl		(Give k		ent's Usual Occupation and of work done during most of working			iness/Industry			
21215-0036	within giene. er tha the N		Elementary/Secondary (0-12) Colle 5+	ge (1-4 or 5+)		gineer			Gov	rernment			
nd	e filed within tal Hygiene. ed other thar event, the N	То Ве	17. Father's Name (First, Middle, Last)					me (First, Middle, I	_				
Z Za	2 should be file th and Mental I ?7 is marked o traumatic eve	ř	Harris Pierpont	Scott			Maude						
Maryland	3 E N B		19a. Informant's Name/Relationship (Type, Print) Polly Sampson / Daught	tor	ı	g Address (Street a Bluberry			-				
	1 and 2 of Healt item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	1	Date		City or Town, State			
Ē	Page nent c ant; If ary or		1 \square Burial 2 $\overline{\mathbf{X}}$ Cremation 3 \square Removal 4 \square Donation 5 \square Other (Specify)			Crematory or other place	i	2/2012	Frederi	.ck, Maryland			
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service Licensee	1 11	22.	Name and Addres	s of Facility	Stauffe	r Funera	1 Home			
	H - 6 0		23a Part 1 Enter the disease promplications	auffici	Do not onto	1621 Opos	ssumtown	Pike, F	rederick	erick, MD 21702			
	Physician/		23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death Onset and Death										
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ă M	the de by the	hysi	1 Yes 2 No 9 Unknown										
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N ta	Physician; this certific ral director,	To Be	examiner?	1 Inpatient 2 □ E	R/Outpatien	Otho	r.	Home 5 Reside	ence 6 \(\text{Other}	(Specify)			
ō	ng Ph fter thi ineral		27. Manner of Death 28a. 1		28b. Time of injury	28c. Injury work	at		ow injury occurred				
ion	Attending I er death. ector: After by the funel	Certificate:	2 Accident Investigation	N. Alli All		M 1	Yes 2 No						
Division of	al or Attending Physis s after death. I Director: After this c ed in by the funeral dire	Cert	4 Homicide determined 286. F	Place of Injury - At hom ouilding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St City or Town	(Street and Number or Rural Route Number, own, State)				
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1. Certifying Physician: To	the best of my knowle	dge, death o	ccurred at the time	, date and place,	and due to the cau	use(s) and manne	r as stated.			
	To the He within 24 To the Fu complete	Mec	only one) 3 LJ Certifying Nurse Practiti	oner: To the best of my	ana/or investi y knowledge,	death occurred at th	ne time, date and p	place, and due to th	e cause(s) and ma				
29b. Signature and title of certifier 29c. License number MDD 71068									99d. Date signed و	(Month, Day, Year)			
			30. Name and address of person who completed	cause of death (Item :	23a) (Type. Pi		11068		0 000	1 60			
	6		SATHYABAMA NAIDU				NTHST	FREDE	ERICK,	MD 21701			
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 5 2012	32. Registrar's Signatu	ire A	arkel		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #10a-f Per FH G933 11/19/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Physician/ Frank Stanley Scheible 1151 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5011501/4 TENINSULD Kag/onto 1000100 If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birtnpu Country) VA Days Hours 434-62-3630 Director 10-18-1945 1**X** M 2 □ F 66 Yrs. Usual Residence of Dece show iral", or items 23a or 28a-f shov Examiner , ust be potfilled at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits VA FL **Greenbackville** AccomackManatee **Bradenton Beach** 1 X Yes 24 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 9th ST. N. 37268 Custom Dr. Funeral 34217-3314 23356 USA P.O. Box Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "naturai", Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Madical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Broker Agriculture permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Stanley Scheible II Sally Fogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 9th St., N, Bradenton Beach, FL, 34217 Joshua C. Scheible/Son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Franklin Cemetery Date 20c Location - City or Town State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2012 Stockton, MD Sign Ture of Fun Al Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. Much 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? 2 1 ☐ Yes 2 ☐ No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှု ER/Outpatient 3 DOA 1 Inpatient 2 Manner of Death

Natural

Accident filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation M 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Conting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signatu of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who co ed cause of death (Item 23a) (Type, Print) BA 15 31. Date filed (Month, Day, Year) State Registrar's Signature **SEP 0 5** 2012 Registrar

12-06819 Lewis J Sprouse Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 30358

	1- For State Certificate of Death Reg. No.											0000	
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										3. Time of Death	
Medical Exami	iner	Lewis Jack	Sprouse					S	September	9, 2012		1138 hrs	
		4a. Facility Name (if not instituted		er)		4b. City, Town		of Death		4c. County of			
		Patuxent River at Marsh Point Mechanicsville St. Mary's											
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Months Days Hours Min.								9. Birth Foreign			
Director		218-02-9098 1XM 2 F 29 Yrs. World S Days 10015 2/25/1983								Cour	ntry) MD		
<u>A</u>		Usual Residence of Decedent 10a. State											
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rland -f sh	ţo		Arundel			Harwo							
Mary r 28s	Director	10e. Street and Number				10f. Zip Cod			10g.	. Citizen of Wh	at Countr	γ?	
ith the Maryland 23a or 28a-f sho notified at once,		4775 I Carmo					20776			US			
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	eral	11. Marital Status 1 X Never Married 2 M	12. Was Deceder Armed Forces			as Decedent of Yes, specify Cu				14. Race White		an Indian, Black,	
or it	Fur		1 Yes	2 🔀 No	1,								
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5-00; led withi Hygiene, other ti	ē	17. Father's Name (First, Middle,	Last)			100011		r's Name (Fir	rst, Middle, Mai	iden Surname)	Building en Surname)		
215-0036 be filed within 72 mtal Hygiene. rked other than "	Be	Lewis Jack C	rosby				E	Emma	Lou Cr	rosby			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	٩	19a. Informant's Name/Relations	er, City or Town	n, State, Z	Zip Code)								
MD 12 short and 127 is unmat		Emma Gearhart/Mother 4775 I Carmody Ct., Harwood,									D 20	0776	
10re, MD 2121 ages I and 2 should be fi nt of Health and Mental it: If item 27 is marked other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation	2 Damawal from 6		Place of Dispo crematory or o	sition (Name of	cemetery,	Da	ate 2	20c. Location -	City or To	own, State	
Pages ent of		4 Donation 5 Other St	_	itate	-		em.	9/17	/12	Belts	vil:	le. MD	
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		21. Signature of Funeral Service			22.	Name and Addr	ess of Facility	Ray	mond-V	vood,	F.H.	., P.A.	
E P P		(. Wos	2		P	О Вох	430,	Dunk	irk, M	4D 20	754	•	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.									, shock, or hea	rt	Approximate Interval Between Onset and		
/Medical Examiner	Medical failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning											Death	
		or condition resulting in death)	Due to (or as a con	sequence of	f):	_							
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8760, ificate be ig physici											delivery Day	y Year	
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P.O. BOX es that the deati igned by the att	by P	Part II. Other significant conditi	ons contributing to dea	th but not re	esulting in the	underlying caus	e given in Pa	art I.				e cause of death?	
rds, P.C requires that been signed	b											oly 4 🗸 Unknown	
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tal Rectian: The certificate ector, page	Bec	25. Was case referred to medical				26,Pla	ace of Death (
n of Vital Records, P.O. Box Ling Physician: The law requires that the death. After this certificate has been signed by the atte funeral director, page 2 should be detached for U	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ient 2	ER/Outpatien		Other ₄	Nursing Ho	ome 5 Re	sidence 6 🗹	Other: S	cene	
of Viding Physic After this		27. Manner of Death 1 Natural 5 Pens	28a. Date of In (Month, Day,	ury Year)	28b. Time of		njury at Work			v injury occurre			
sior ttend death ctor: y the	ă	J Pelic	tigation Id 9-9-		fd 11:	38 am	Yes 2 🗶			drowned			
Division of Vital Records, pital or Attending Physician: The law require ours after death. Peral Director: After this certificate has been si filled in by the funeral director, page 2 should be			not be			et, factory, offic	e building, etc		or Town, State	Patuxe	nt Ri	Route Number, City	
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Division To the Hospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	Check only one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										ause(s)		
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30. Name and address of person who completed cause of death (Item 23a)										, ==			
			nt Medical Examine		,	re Street, B	altimore, N	MD 21223	3				
St	ate			ar's Signatu	ro a d								
Regist	rar	31. Date filed (Month Day Year)	27117 Cen	we	p. 19	arkal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ SHAHEEN 0538 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberlance Regional Medical Conte Allegany . Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 🗆 M 2 🔼 F PAKISTAN 58 10 25 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at **Funeral Director** LAVALE 1 Yes 2 No ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a SUNSET AKISTA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: ASIAN 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) DAN HOME HOME MAKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည SIDDIQUE BILQUIS MOHAMMAD SIDDIQUE 19a. Informant's Name/Relationship (Type, Print) DAU THTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. ASHRAF CHAUDHRY/ 106 SUNSET 20a. Method of Disposition 20b Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 31/12 4 Donation 5 Other (Specify HO #1070 22. Name and Address of Facility A DEN MUSLIMFUNERAL ST. WOODBRIDGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SERSIS FULMINANT disease or condition resulting in death) Medical **Examiner** TWO DAYS SYNDRUME HEPATORENAL Sequentially list conditions, Examine if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LIVER FAILURE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🛣 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) D0037417

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OBERTA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Prince George's Council House Senior Ind. Living Suitland If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 214-28-9191 1 M 21/2 F 06/24/1928 North Carolina 84 or 28a-f shov ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Prrince George's Suitland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3940 Bexley Place #718 20746 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de Ital Hygiene. ed other than "natural", or it Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housekeeping Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit. Page 1 and 2 should be 1
Department of Health and Mental Important: If Item 27 Is many injury or other. ည Eddie Harris Susie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Saxton (Daughter) 12800 Marlton Center Drive, Upper Marlboro MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Heritage Memorial Pk 8/28/2012 Waldorf, MD 21 Signature of Funeral Service Licenter 22. Name and Address of Facility Tri-State Funeral Services 814 Upshur Street NW, Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priset and Double Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burlal-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ò Month Day Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗆 Yes 2 No ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? —1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 \square Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun Natural ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Great Post of the Cause State Course at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 29c. License number 29d. Daye signed (Month, Pay, Year) 454 completed cause of death (Item 23a) (Type, Print) - Mo EY-ENS

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

inductive that Davis, Areatha 5 8/23/12 0205 Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 30361 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8–23–2012 Year Sturdivant-Davis Areatha 0205 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Bethesda, Maryland Mantagery Saburban Hospital Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 578-52-1849 1 🗌 M 2 🕱 F 72 1-5-1940 Washington D C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sl notified Temple Hills Md Prince George's 1 Vas 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? be ms 23a Funeral 3607 Riviera Street 20748 USA "natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Yes 2 No 1 Yes 2 No Specify: If Yes, Give Completed Specify 3 Widowed 4 Divorced Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Program Assistant Federal Covernment (HJD) Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lee Sturdiyant Annie Mae Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4740 Ridoeline Terrace Bowie Maryland Gregory Davis, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 3 Removal from State 8-31-2012 Lincoln Memorial Cemetery Suitland, Maryland 4 Donatio 21, Signatu 22. Name and Address of Facility Ronald M Taylor 11 Funeral Home 1722 North Capital St NW Washington DC 20001 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. shock, or heart failure. Land ediate Cause (Final Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Cardianyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a conscionable on ESRD Diabetes Mellitus resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? P Pregnant at time of death Other (specify) Month Dav Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 2**X** N 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best gr my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8-24-2012 7 5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd Bethesda Maryland 20814 Purnima P Josh MD

State Registrar 31. Date filed (Month

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	Physicia Medic			VART				2. Date of Death	1	Year	Time of Death
	Examin	ner	4a. Facility Name (if not institution, g 2224 ALICE AVE	ive street and number)		4b. City, Town, or OXON HI	r Location of Death ${ m LL}$		4c. County	of Death	
	Funeral Director		5. Social Security Number 249-15-4837 Usual Residence of Decedent		In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/3/196		Country)	(State or Foreign
	yland f show ed at	ctor	10a. State 10b. County		Oc. City, Town or Lo-	cation	<u> </u>				Inside City Limits
	the Mar or 28a	Dire	MD PG 10e. Street and Number	[0	OXON HILL	10f. Zip Code		10	Da. Citizen of	What Country?	Yes 2 No
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9800	urs after deat ural", or iten I Examiner I	by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 12. Was Decedent Even Armed Forces? 1 Yes 2 No No Year or Dates.		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Blad	e - American Inck, White, etc.	ndian,
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 1.2 TH		(Give	O NOT use retired)	ation during most of worki	ng	18b. Kind of B	usiness/Industr $\Gamma { m E}$	у
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	and 2 shoul Health and I tem 27 is mother trauma		19a. Informant's Name/Relationship XAVIER MAURICE S			-	and Number or Rura E, OXON H			state, Zip Code))
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place of Dispo		re)	Date 2	0c. Location -	- City or Town, S	State
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Vital	ysician: is certific director,	To Be	25. Was case referred to medical examinar? 1 Yes 2 No	Hospital:	: 2 ☐ ER/Outpatien	Othe	er:	only one) me 5 Resider	ice 6 0 Othe	er (Specify)	
Jo (ing Phys I. After this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	28b. Time of	28c. Injury work	/ at // 2	28d. Describe how			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be	- At home, farm, stre Specify)		Yes 2 □ No	28f. Location (Stre City or Town,		er or Rural Rout	te Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2 Medical Exa	hysician: To the best of my iminer: On the basis of exal urse Practitioner: To the b	mination and/or invest	igation, in my opinio	n, death occurred at	the time, date and	place, and due	e to the cause(s)) and manner stated.
	Voit Fo t		29b. Signature and title of certifier	· Alex	6 70	29c. License				(Month, Day,)	
	2-5m		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Type, P	rint)	153921		1 1	7	
	Stat	te	31. Date filed (Month, Day, Yelf)	vester 3e	Signature Signature	(ax W)	, ve of	everl	5 M.	AZCA.	wd
DUI	Registra		SEP (to 20)	1:10 141	A FIRM					· · ·	

Registrar

State

Thomas Tohnson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-C

32. Registrar's Signatur

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31. Date filed (Month, Day, Year)

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Frederick

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Please Type or Print in Black Indelible Ink. Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day net rar 3:03 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns H opkins timore Social Security Number 8. Date of Birth (Month, Day, Y April 15 Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours Director Turkey 130-34-5084 1 ₩ M 2 🗆 F 85 Usual Residence of Decedent l Hygiene. other than "natural", or Items 23a or 28a-f ahov vent, the Madical Examinar must be notified at 10a. State 10b. County filed within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director 1 x Yes 2 ☐ No MI Oakland Rochester Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3256 Palm Aire Drive 48309 Turkey / USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Doctor Medicine permit. Page 1 and 2 should ba filed w Department of Health and Mental Hyg Important: If Item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Murside Oksuz Osman Hulusi Turan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 First St. #1529, Alexandria, VA 22314 Osman Turan, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Zinctriikuvu Mezar 9/10/2012 Sisli, Istanbul 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lice Everly Wheatley Funeral Home 22. Name and Address of Facility M.0 1500 W. Braddock Road, Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ineuroendoccine Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Privations: The law comments of the attending physicien and within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlai-transit completely filled in by the funeral director, page 2 should be deteched for use as the burlai-transit. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural N 5 Pending injury WOFK? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ara M. Kelinson M. Phis 20 52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rubinson ara MP, PhD 1800 Orkans Street 31. Date filed (Month, Day Year) 2. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas 1 - State Registrar	State of M		d / Depa		Health and			0010	2 30365
Physicia Medic		1. Decedent's Name (First, Middle, I	Last)					2. Date of De Septemb	ath	ĭ, 20Ĭž	3. Time of Death 10:55P M
Examin			/eterans			Charlo	or Location of Deat		\$t	. County of Deat	S
Funeral Director		5. Social Security Number 579–28–6895 Usual Residence of Decedent	5. Sex 1 ☐ M 2 🛣 F	e (In yrs. Ia 87	st birthday) Yrs.	If Under 1 Year Months Day			th y, Year)	924 Wash	thplace (State or Foreign D.C.
Maryland :8a-f show	rector	10a. State 10b. County Maryland Charl	es		Town or Local	cation					10d. Inside City Limits 1
with the l s 23a or 2 nust be no	Funeral Director	10e. Street and Number 4010 Gardiner Ro				10f. Zip Code	601		10g. Ci	tizen of What Co A	untry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11, Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 [X] Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? d 1 Yes 2 1 If Yes, Give Year or Dates.	Ever in U.S No	1	Vas Decedent of Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, White Specify: Wh	e. etc.
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. Page 1 and tment of Heal tant: If item ; jury or other		20a. Method of Disposition 1		CE	emetery, cren land V	sition (Name of natory or other p	. Sept	Date . 14, 20)12 (,
permit. Departn Imports any injt		21. Signature of Funeral Service Lic	Breus				^{Iress of Facility} Hu Washingto				20601
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or content failure. List only immediate Cause (Final disease or condition resulting in death)	omplications that caused by one cause on each line a. Due to (or as a	-he	nca		ying, such as cardiad		rest,		Approximate Interval Between Onset and Death
be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.								
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregna Other (specify)				23d. Date of del Month	livery Day Year
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Stat	0	30. Name and address of person when Casses 31. Date filed (Month, Day, Year)	32. Registra	9 CK	arlotte	riiiq	d, Charlos		l, m	D 206	22
Stat		31. Date filed (Month, Day, Year)	2012	J	4 4	- 41					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Augus Medical institution, give street and number 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Seouth Months Min. Director 1 □ M 2 K or 28a-f show 10d. Inside City Limits 10a. State 10b 10c. City, Town or Location within 72 hours after death with the Maryland Director or than "natural", or Items 23a or 28a-fs 1 Yes 2 ☐ No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 D Yes 2 D No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, The Mea Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eisst, Middle, Maiden Surnar Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Name Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) m of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End-Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examir completely filled in by the funeral director, page 2 should be detached for use as the burial-transil Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day 1 ∐ Yes ∠ ₪ 9 ☐ Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 ☐ No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nslajapatheMD 916/12 00057465 Bom

State Registrar DHMH 17 Rev 06-2011 15 lajaparsemo

31. Date filed (Month, Day, Year)

Registrar's Signa

Smilh IN

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ORIGINAL

Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Hambe Medical Examiner acility Name (if not institution, give street, and number) 4b. City, Town, or Location of Death County of Death Nilson of thers burg If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Nassau 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 - M 2 - X Hours 85 Director 326-26-2833 .0/09/1926 Rahamas Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral 333 Russell Avenue Apt 238 20877 United States permit. Page 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or are. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Specify: Completed 3 Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) P.G. County Board of Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Financial Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Alfred Kemp Addie Linda Bethel Key 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott C. Thompson(Son) 9805 Stayman Court, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State September 5, 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Survive Lious 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive, TRACY 4 . TUVE M01117 Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Deatl Physiciani disease or condition real Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conseque, ce of) Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Month Day the Unknown Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate 21 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tr of certifier 10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type

slecular Prive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Barbara Lee Thomas 31°, 2012° 4:50P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1811 Keokee Street Hyattsville Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months WestinVirginia 235-66-9191 NOV. 1942 69 Director Usual Residence of Decedent show 10b. County 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Prince George's Hyattsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n with 1 Funeral 20783 United States 1811 Keokee Street items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify Black 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) the Administrative Assistant U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meating or other? ည Anna Lee Redman Elwood Hollingsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Keokee Street Hyattsville, Maryland 20783 19a. Informant's Name/Relationship (Type, Print) Nicole Camp -daughter 20a. Method of Disposition
1 □ Burial 2 M Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place
Metropolitan Crematory 20c. Location - City or Town, State 9/4/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald AvessBorgwardt Funeral Home, PA Wonald 200 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause E ter or certain g Cause (Disease or iinjury Due to (or as a consequence of) buria transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe To the Hospital or Attending Physician: The 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 Yes 2 No 5 Pending

Registrar

DHMH 17 Rev 7/2009

State

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Medical

☐ Accider☐ Suicide Accident

4 Homicide

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

SEP 0 5 2012

29a. Certifier (Check

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shadi Soufi, M.D. PH 1150 Varnum Street, N.E., Suite 318 Washington, DC 20017

🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD036623

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

September 4, 2012

City or Town, State

			Please	Type or Prin					-		_	ble.	
			For State	State of Mar	yland				Mental Hy	_		10	20260
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- Mary	Examin		4a. Facility Name (if not institution, give s	,				r Location of Dea		40	c. County o	f Death	
7	Funcion		Suburban Hospita 5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Secu		In yrs. last	t hirthday)	Betheso	a I If Under 24 Hrs	8. Date of Bi		Contgo		lace (State or Foreign
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ပ္	er dea or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married :	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No		l II	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puer	specify Yes or No to Rican, etc.)	-	14. Race Black	- Americ , White, e	
003	urs aftuural", ural",	ted k	3 Widowed 4 💢 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 💢 No	Specify:			Specify:	Whit	:e
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) David G. Tulkin						ame (First, Middle	, Maiden	Surname)		
17/8	ould be d Mer marke matic		19a. Informant's Name/Relationship (Typ.	an Print)		401 14 77		Mae Coo			T 0:	. ~ .	
Ma	d 2 shoalth an 27 is 27 is ir trau		Laura P. Hinkle -	•	- 1		g Address (Street Cross Ro						iode)
Baltimore,	of Hez of Hez if item		20a. Method of Disposition 1	Dameual from State		ce of Dispos	sition (Name of natory or other place		Date		_ocation - (wn, State
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			23a. Part 1. Enter the disease, or compl		ne death. I							.005.	Approximate
	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.	tast	inal	Pleading	65					Interval Between Cnset and Death
	Medical Examiner		resulting in death)	Due to (or as a c									
		ner	if any, leading to immediate	Due to (or as a c	onsequen	nce of):							*
	executed ian and irial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	·									
		al E	resulting in death) Last	Due to (or as a co	onsequen	ice of):							
Box 68760	eath certificate be attending physicie d for use as the bu	Physician/Medical		d									
89)	ending use a	an/M	23b. Was decedent pregnant	3c. If yes, outcome of			Ectopic pregnanc	24			23d. Date	of delive	ery
Bo	death	/sici	in the past 12 months? 1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4 Pregnant at til			Other (specify)	, y			Mon	h	Day Year
P.O.	requires that the des been signed by the s should be detached		Part II. Other significant conditions con	tributing to death but	not resulti	ing in the ur	nderlying cause gi	en in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
S, I	uires t n sign uld be	Completed by	Metastatic B-Cell	lymphoma,	Left	extr	emity de	ep 	1 🗆	Yes 2	!□No 3	∃ □ Prob	ably 4 💢 Unknown
Sorc	aw red as bee 2 sho	plet	vein thrombosis, p	lural effu	sion	, chr	onic kid	ney	24a. Was				esy findings available inpletion of cause of
Be	The k	Con	disease.						perf	ormed?	de	ath?	_
ita I	slcian: certifii irector	m	25. Was case referred to medical examiner? 1 Yes 2 X No	ospital:			Oth	ace of Death (Che					
of V	g Phy er this neral d	te: To	27. Manner of Death	1 K Inpatient 28a. Date of injury	28	Bb. Time of	28c. Injur	y at	Home 5 Resi 28d. Describe				· · · · · · · · · · · · · · · · · · ·
no	eath. or: Aft the fur	ifical	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Y	ear)	injury	M 1	Yes 2 No					
Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury building, etc. (\$		e, farm, stre	et, factory, office		28f. Location (City or To			or Rural	Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my	knowled	ge, death o	ccurred at the time	e, date and place,	and due to the c	ause(s) a	and manne	r as state	d.
	the Ho hin 24 the Fu nplete		ority one) 3 - Contifying Nurse	er: On the basis of exan			death becamed at t	he time, date and		the caus	e(a) and me	100 BB 100 B	
	vit oor		29b. Signature and title of certifier	rablet			29c. License			29d. Da	ate signed	Month, E	
	^		30. Name and address of person who co		h (Item 23	Ba) (Type, Pi		1068405			0.11	J-1(L	VIL
df	W 10		David Guevara-Nieto, M	D 8600 01d G	eorget	town Ro		da, Maryla	and 20814				
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra s	Signature	A	have	,					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 10d, per 111, gg 1 - 1 - 12 sm Certificate of Death Reg. No. Reg. No 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Clifford M. Temple 80 26 2012 12:45 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Glade Valley Nursing Home Walkersville Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F Yrs Director 579-05-5769 87 11/22/1924 Wa<u>shington, D.C</u> Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: if them 27 is marked other than "naturel", or terms 23a or 28e-1 ehron Page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Walkersville Funeral Director Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 56 W Frederick Street 21793 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 No Yes 2 No No 15 Yes, Give 1943-46 Year or Dates: 1 Never Merried 2 Married White 1 Yes 2 No Specify: Specify: Be Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cartographer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clifford Earl Temple Cora Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Temple - Son 1310 Yellow Tavern Ct. Herndon, VA 20170 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/07/12 Adams-Green Funeral Home Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 721 Elden Street Herndon, VA 20170 Adams-Green Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical minutes Examiner Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? ata has been signed by the a paga 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were a utopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificata s effer daam.

*al Director: After this cerum.

*n by the funeral director, p? 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2€ No 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

filled in by To the Hospital within 24 hours To the Funeral I

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certi D43091 9-1-12 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 801 Tou House Ave, Frederick, MA 21701 Zaidi 31. Date filed (Month, Day, Year) 62. Registrar's Signature 1 2012

Registrar **DHMH 16 Rev 6/95**

State

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		1- For State Registrar		Certifica	ate of L	Death			Reg	j. No.	12 0001
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle	aron Tragesei						. Date of Death	Day Year	3. Time of Death 1535 hrs
		4a. Facility Name (if not institution Frederick Memorial Ho				City, Town, Frederick	or Location o	of Death		4c. County of I	Death
Funeral				(In yrs. last birt	hday)	If Under 1 Ye	ear If Unde			Birthplace (State or oreign	
Director		212-27-5724 Usual Residence of Decedent	1XM 2 F 2	24	Yrs.	MONUIS	ays Hours	Willin.	Oct. 9	, 1987	countryMaryland
w any	Ì	10a. State 10b. County	1	0c. City, Town		1				<u> </u>	10d. Inside City Limits
Maryland 28a-f show d at once.	ito	Maryland Fred	erick	Monr		10f. Zip Code			140-	. Citizen of What	1 Yes 2 No
h the Ma 13a or 28	I Director	3452 Emys Pla	ace			217	70		100	U.S.A.	
MOTE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f about the traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Ma	1 Yes 2 X	ver in U.S.	If Yes	, specify Cub	an, Mexican,		cify Yes or No- can, etc.)	14. Race - A White, e	umerican Indian, Black, tc. White
ours afte	اھ	3 Widowed 4 Divo	rced or Dates: fy only highest grade complete.	eted) 16a. [Decedent's	es 2 X N Usual C∞up	ation (Cive I	kind of wor	k done 1	Specify: 6b. Kind of Busin	
Jre, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", her traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)) '		t of working lit	fe. DO NOT	use retired	1)	N/A	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than matic event, the Medica	Be Co	17. Father's Name (First, Middle, I Mark A. Trage		<u> </u>				s Name (F Ann B	irst, Middle, Ma	iden Surname)	
MD 21 12 should 1 th and Mer 127 is man umatic ev	٥	19a. Informant's Name/Relationsh LeeAnn Geisle	ip(Type, Print) r, mother	19b 34	. Mailing A 452 E	ddress (stre mys P1	et and Num ace, I	ber or Rur Monro	al Route Number	er, City or Town, S	State, Zip Code)
Baltimore, Mi permit. Pages 1 and 2 Department of Health a Limportant: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2XX Cremation			ory or other	place)				20c. Location - Ci	chsburg, MD
Baltimore, permit. Pages I an Department of Hea Department of Hea Important: If itel important: In itel injury or other tr	-	4 Donation 5 Other Spe 21. Signature of Funeral Service	icensee	00255			-			neral Horerick, MI	
Physician	\dashv	23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that caused the								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Methadone] Due to (or as a consequ		ation	l					Death
	اچ	Sequentially list conditions, if any, leading to immediate	b	ience of):	-						
d sit	티	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):			_				
ficate be executed g physician and the burial - transit		X UNPENDED	d AMENDED 23a, 2	27,28a-	f,per	me,g9	31 9-2	25-12	sm		
760, ficate be g physic the bur	Wec	IF FEMALE: 35. Was decedent pregnant in the	23c. If yes, outcome					•		23d. Date of del	ivery
Records, P.O. Box 68760 The law requires that the death certificate b icate has been signed by the attending physipage 2 should be detached for use as the bu	Physician/Medical	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at tim			death 3 (Specify)	Ectopic	pregnancy	, 	Month	Day Year
P.O. E	y L	Part II. Other significant conditio	ns contributing to death be	ut not resulting	in the und	erlying cause	given in Par	t I.			e to the cause of death? Probably 4 Unknown
rds, I	eted					 			24a. Was an	24b. Wer	autopsy findings available
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed as Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit.	Completed	<u> </u>							autopsy performe 1 ✔ Yes 2	ed? deat	
n of Vital I	e n o	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/Out	tpatient 3	_	e of Death (0			sidence 6 0	ther:
ion of Virtualing Physicath. tor: After this the funeral dir		27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day, Year)		ime of Injur		ury at Work? Yes 2 🗶 J	- 1	d. Describe how	v injury occurred	
Division pital or Atto tours after de seral Directo filled in by t		2 Accident Investig 3 Suicide 6 X Could determ	28e. Place of Injury		m, street, f	actory, office	building, etc.				Rural Route Number, City
0 - 3 >	<u>بر</u> (29a. Certifier 1 Certifying Phy	sician: To the best of my kr	nowledge, deat	h occurred	at the time, d		ce, and due	e to the cause(s) and manner as	stated.
F. v. i	Me	29b. Signature and title of certifier	and manner stated.			29c. Licen					Month, Day, Year)
		Carde	Hellac	h /// 25 :		O.C.	M.E.		8	September 16	, 2012
			ssistant Medical Exa	miner 900	W. Bal	timore Str	eet, Baltin	more, M	D 21223		
Stat Registra	te ³ ar	SEP 2 1 201	2 32. Registrar's S	Signature And	ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e, per fh, g931 9-21-12 sm
State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Por amend item 5 per fh g932 10-9-12 vt
Certificate of Death
Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1303 M Theresa Rebecca Toporzycki Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 215-32-**Director** 5843 1 □ M 2X□ F Yrs 01/30/1930 MD 82 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes X No MD Carroll Westminster 10e. Street and Number 1217 Sullivan Road 10f. Zip Code 10g. Citizen of What Country? 21157 USA . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event ""-" once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Random House 12 warehouse worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Bauerlein Harry Rickle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1314 Washington Road, Westminster, MD Bernard Toporzycki/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Garden 09/17/2012 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fa**Phyltts Funeral Home and Chapel, PA** 21. Signature of Funeral Service Licensee arl 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): should be detached for use as the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed' Endicar To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tyes ဂ္ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St. 2110 31. Date filed (Month, Day, Year) State Registrar

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print); ation Blud, Glen Busnie, mD, 21061

Maryland 21215-0036

Baltimore,

Box 68760 P.O. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Lazu Vega M 2012 7:40 Medical August 4a. Facility Name (if not institution, give street and number)
La Familia III1210 Downs Drive Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring If Under 24 Hrs Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 092-28-5311 Director 1 □ M 2 🗵 F 92 Yrs. May 15, 1920 Puerto Rico 10a. State 10c. City, Town or Location Director 10d. Inside City Limits items 23a or 28a-f sl MD 1 Ves 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1013 Loxford Terrace 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ŏ δ 1 Never Married 2 Married other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Puerto Rican If Yes, Give Year or Dates Specify:White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Own Home and Mental Hygie is marked other be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isaih Lazu Julia Muriel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Farmer/Granddaughter 1013 Loxford Terrace, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sept. Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2012 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W.. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caus. If the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Severe Aortic Stenosis 1990 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician a for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month signed by the et id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Debility, Diabetes, Dementia 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2X N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Certificate: To 2 🖾 No Assisted Living Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760 Records, To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funetel Director: After this certificate has been sompletely filled in by the funeral director, page 2 should Division of Vital

Registrar

State

0

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Moranh

Mary Blanken, CRNP

SEP 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #240

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R098788

29d. Date signed (Month, Day, Year)

eptember 4, 2012

29c. License numbe

11800 Tech Road, Silver Spring, MD 20904

3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30375 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Alberto 2012 Vasquez August 31 2:05 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Rirth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 215-77-8299 1**X** M 2 □ F 42 Usual Residence of Decedent Jan. 21, 1970 Peru 28a-f show must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 100 Croydon Court, Apt. 1 20901 USA filed within 72 hours after death "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Specify: White 1X Yes 2 No Specify: Peruvian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Housekeeping Hote1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filed trent of Health and Mental H tant: If item 27 is marked oti jury or other traumatic even Victor Santiago Vasquez Clara A. Moron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara A. Vasquez/Mother 100 Croydon Court, Apt. 1, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ate of Heaven Cemetery 1 A Burial 2 Cremation 3 Removal from State Important: If any injury or once. Gate 4 Donation 5 Other (Specify) Silver Spring, MD Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the dex. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ E. Coli Infection Medical resulting in death) Due to (or as a consequence of) Examiner Urinary Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Hodgkins Lymphoma Due to (or as a consequence of) attending physician the buri Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ On Chemotherapy, HIV, History of Rectal Cancer Completed 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No Yes 2 X No 1 Tes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury

Box 68760 P.O. Division of Vital Records, completely filled in by the funeral director. To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Certificate: 1 X Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier only one) 29b. Signature and title of certifier

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

August 31, 2012

1 Yes 2 No

D68681

30. Name and address of person who completed ca se of death (Item 23a) (Type, Print)

2012

Charu Maheshwary, 1500 Forest Glen Road, Silver Spring, MD 20910 MD

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31. Date filed (Month, Day, Year)

SEP 04

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30376 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Malinda Month 08 J., Wong 0728 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bulhmore, mp mirwim Many Land Medica centu Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 216-64 78 55 **Director** 1 🗆 M 2 👿 F 08 Ö show 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD 1 ✓ Yes 2 ☐ No CAMYVI 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a208 21613 MS items be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. "natural", 3 ☑ Widowed 4 ☐ Divorced Completed BICK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Nursinghome Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Ments Important If item 27 is marked any injury or other မ onnie tzgerald 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral minstenst 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or s a con quence of): Examiner SYSL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death
Unknown signed by the at Id be detached fo 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should k 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after dearn.

To the Funeral Director: After this certificate hompletely filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🗹 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PEVUNTER MIT. ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 30. Name and add

31. Date filed (Month, Day,

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		Please Type or Print in Black		_										
			partment of Health and leartificate of Death	, ,	0010 00077									
Physicia Medic		1. Decedent's Name (First, Middle, Last) Karen M. Wisner		2. Date of Death Month August	Day Vear 23 2012 0542 M									
Examir		4a. Facility Name (if not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll County									
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217–36–2390 1 M 2 🔀 F 72 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) 1939 Maryland									
28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll County Hampstea	ad		10d. Inside City Limits 1 🔀 Yes 2 🗆 No									
s 23a or lust be r	Funeral D	10e. Street and Number 3805 Sunnyfield Court	10f. Zip Code 21 074	_	Citizen of What Country? nited States									
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▼ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ▼ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white									
ene. r than "natu the Medical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) ail sales	king	o. Kind of Business Industry									
Mental Hygi arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Carl Momberger		ne (First, Middle, Maid Hopkins	en Surname)									
Health and Pam 27 is ma		Melissa Spittel / daughter 32	ailing Address (Street and Number or Rui 55 Charmil Drive	Mancheste	r, Maryland 21102									
rtment of H rtant: If ite njury or oti		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Crenation	. 24, 2012 Ha	Location - City or Town, State mpstead, Maryland									
Depa Impo any i		21. Signature of Funeral Service Licensee M01072		line Funer eet Hamps	al Home tead, Maryland 21074									
ysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a bonsequence of both care in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	enter the mode of dying, such as cardiac Ory Facles	or respiratory arrest,	Approximate Interval Between Onset and Death									
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sician and burial-transit	ical Examiner													
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s c ert ific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpa	26. Place of Death (Chec		C Chlor (Crosife)									
ath. r: After this ie funeral c	l' I	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation 28a. Date of injury (Month, Day, Year) injury (Month, Day, Year)	of 28c. Injury at	28d. Describe how in	6 ☐ Other (Specify) jury occurred									
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hin 24 hou the Funer npleted fil	Medical	29a. Certifier (Check only one) 1	restigation, in my opinion, death occurred a e, death occurred at the time, date and pla	at the time, date and place, and due to the cause	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.									
Sol With		29b. Signature and title of certifier NO NOTE OF CONTROL IND	29c. License number 10054	218 0	8 - 23 - 2012—									
10		30. Name and address of person who completed cause of death (Item 23a) (Type DR, Ramers, 3	e, Print) Malcalmd	une, we	8-23-2012- 4-141444 MD 2/157									
Stat Registra		31. Date filed (Month, Day, Year) AUG 2 7 2012 33 Registrar's Signatue	all											

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wayne Sherlock Woodward Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington County Meritus Medical Center Hagerstown If Under 24 Hrs. Hours Min Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 229-30-8218 **Director** 82 1 XM 2 □ F Yrs March 9,1930 Virginia Usual Residence of Decedent 28a-f shov 10c. City. Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11818 Peacock Trail 21742 U.S.A 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 4 8 ed other than "natural", or iter event, the Medical Examiner Black White etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1946 Year or Dates.195 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Systems Load Dispatcher Electric Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Lawrence Hunter Woodward Celeste Virginia Kingry traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau David Woodward-son 119 Greenbriar Lane Dillsburg, PA 17019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cemetery 9-14-2012 | Hagerstown, MD 22. Name and Address of Facility Touglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_, sician Cevebro Vasculer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Aspiration neumon 1 as the burial-trar and Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 Inpatient ER/Outpatient 3 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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Mechical

Campus

MN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITAK

31. Date filed (Month, Day, Year) SEP 1 8 2012

10/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 30, 2012 ear 4:10 A William S. WITKIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Ft. Washington Health & Rehab Center Ft. Washington If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 579-03-6754 **Director** 1**X**□ M 2 □ F 97 May 12, 1915 Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Accokeek Maryland 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20607 2311 Rockwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Maryland 21215-0036 whi te 1 Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store 0wner 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Segal Harry Witkin injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 Rockwood Road, Accokeek, MD 20607 Department of Health an Important: If item 27 is any injury or other Linda Witkin, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 08/34/12 1 X Burial 2 Cremation 3 Removal from State Capitol Heights, MD National Capital Hebrew Cemetery 4 Donation 5 Other (Specify) 21. Signature of uperal ervice Licensee Tanchinsky selection Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 1 Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director. After this certific, completely filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director director, the funeral director director director director, the funeral director director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director direc 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year, D 42995 August 30, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Potter,

Edger V. Date filed (Month, Day, Year) Jr.,

M.D., 12017 Ft. Washington Rd., Ft. Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day, 2012 John Austin Willis 2:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Knoxville 3546 Cemetery Circle If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Director 265-89-8970 46 1 🛣 M 2 🗆 F April 21, 1966 Florida Usual Residence of Decede item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Frederick Knoxville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21758 United States 3546 Cemetery Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedon. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Underground and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Pipelayer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gloria Mobley Harold Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3546 Cemetery Cir. Knoxville, MD 21758 1 and 2 s of Health i Ruth Willis / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory 20c. Location - City or Town, State Sept Date4. Department of Important: If it any injury or o once. 1 Burial 2 K Cremation 3 Removal from State Frederick, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Emeral Solvice Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart ailure. L Interval Between Immediate Cause Final disease or condition resulting in death) Onset and Death Physician/ adenocaranowa Metasta Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? igned by the atte be detached for Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No After this certificate To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide determined

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: completely filled in by the funeral 24 hours after deat Funeral Director:

Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier September 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Dr, Ste 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 5 SEP 0 Registrar ORIGINAL

within 2 To the

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State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Everett Wills Augus 9:50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Future Care Pineview Nursing Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year, 218-38-6431 72 Director 1 □XM 2 □ F 06/14/1940 MD or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20685 3610 Williams Wharf Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give ੬ "natural", or Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Depaarlment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", cere in jury or other treumatic event, the Medical Eventones. Specify: Black 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Union onstruction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herold Wills Mary Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ephonia Wills/wife 3610 Williams Wharf Rd. St.Leonard, MD 20685 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Brooks UMC Cem. 1 Burial 2 Cremation 3 Removal from State 9/8/2012 St. Leonard, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell121. Signature of Funeral Service Licensee Funeral Home, 1451 Dares Beach Rd. Prince Fred., MD2067 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nemu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by isease 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check) only one and title dertifier 29b. Signat 29c. License number D0023337 2612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Doroth 106 Lane INE VIEW WI 31. Date filed (Month, Nay, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Them I per doc g932 10-2-12 vt
State of Maryland / Department of Health and Mental Hygiene For State 30382 Certificate of Death Reg. No. 4 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 08 - Adelin Albertha Wright 11:49 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ballimore Maryland Kedical Baltimore niversity Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year)1950 **Funeral** Hours 770-01-1063 Jamaica, West Indies Director 1 🗆 M 2 🗶 F 61 December 29. Usual Residence of Decedent 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified 28a-f Maryland New Carrollton 1 X Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 0 10g, Citizen of What Country? ms 23a or must be Funeral 20784 5464 - 85th Avenue; Apt. 102 United States items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 10 þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working marked other than matic event, the Me ementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha 12th grade Certified Nursing Assistant Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Frances Smalling Wright other traumatic ^{19a,} Informant's Name/Relationship (Type, Print) Boisie L. Grant (Husband) Eric Anthony Smith (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5632 Spanish River Road; Fort Pierce; Florida 34951 item Oct.Dal2 20a. Method of Disposition 20b. Place of Disposition (Name of Wright, Family 190 other place)

Heritage Hemorial Cemetery 20c. Location - City or Town, State St 012 Elizabeth, Jamaica Department of Important: If it any injury or o ō X Burial 2 Cremation 3 Removal from State Maldorf, Maryland

Name and Address of Facility R. N. Horton Company Morticians, ☐ Donation 5 ☐ Other (Specify) Sign tu of Funer MU1421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastahic gastric (den curcinoma Due to (or as a consequence of): Physician/ disease or condition resulting in death) Metastahe Medical Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Due to lor as a consi quence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy performed Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . vipletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the compl 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month. Day, Year) Bricker, Rory 1659670891 08,31,2012 3:5M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Maryland Medial Conter. 22 S. Green St Bulkinine 21701 Bricker MD University 31. Date filed (Month, Day, Year) SEP 0 6 2012 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year White Elizabeth 8:30A Medical ugust 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Min (Month, Day, Year) Director 1 🗆 M 2 🕱 F 60-32-0323 Usual Residence of Decedent 91 Aug. 11, 1921 VA ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Accokeek MD PG10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2302 Loretta Court 20607 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give than "natural", Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates Black other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Personnel Assistant Interior Dept. marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Viola Gooch James Gooch and l 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Loretta Court
Accokeek, MD. 2060

20b. Place of Disposition (Name of cemetery, crematory or other place)

8/29 1 and 2 s if Health item 27 Patricia Howie/Daughter 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o Riverdale Park Crematory 1 Burial 2 XCremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Riverdale, MD. 22. Name and Address of Facility Hodges & Edwards F.H. Signatur of Funeral Service Licens 3910 Silver Hill Rd., MD.20746 Suitland, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) C ANCER Onset and Death BREAST METASTATIC Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to for as a nonsecurine off Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by PNEUMONIA Records, 1 Yes 2 No 3 Probably 4 Unknown been HEART CONGESTIVE FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was autopsy performed ate has this certificate 1 Yes 25. Was case referred to predical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide after death Director; A d in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours aft le Funeral Di bletely filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

35,4

within 2

(Check

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signa

DHMH 17 Rev 06-2011

State Registrar Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0064986

29d. Date signed (Month, Day, Year)

8/25/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c per DVR G931 9/26/12 dk
State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08/28/2012^{Year} 8:50 p M ARTHUR EDWARD YOUNG, SR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgamery Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 217-36-9802 1 XM 2 | F 8/15/1937 VA 75 Usual Residence of Dece ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. Count 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Montgomery Germantown 1 Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 **USA** 12501 Middlebrook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 7 to Health and Mental Hygiene. If item 27 is marked other than a rother traumatic event, the Mis Elementary/Secondary (0-12) College (1-4 or 5+) Custodian-MCPS Maintenance llth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Cross Paul Young, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19235 Esmond Terrace, Germantown, MD 20874 Felicia White/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If its
any injury or of 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Norbeck Memorial Park Silver Spring, MD 9/7/2012 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service Licenson 246 N. Washington St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Tongue Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical $\frac{+7}{2}$ C Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 😾 Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: Hospice <u>م</u>| 1 🗌 Yes 2**½** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) Registrar SEP 0 4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sevontremberray 2 Physician/ 2/0/12 10:05Pm Nancy Lea Young Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Director 1 | M 2 | F 215-66-9907 81 July 3 1931 Tennessee 2 should be filed within 72 hours after death with the Marylend th and Mantal Hyglene. 27 is marked other then "hatural", or itema 23e or 28e-f show traumatic event, the Medical Eventhar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Damascus 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 10109 Ridge Manor Terrace, Unit A United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Marital Status 14 Race - American Indian Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hassie Perry John Roscoe Purkey end 2 should by Haalth and Ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 28416 Kemptown Road, Damascus, Maryland Brenda Swecker/Daughter 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Paga 1.
Der ertment of I Important: If It any injury or of 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 09/06/12 Frederick, Maryland 21. Signature of Furfaral Service Licenses 22. Name and Address of Facility Barber Funeral Home P.O. Box 5038, Laytonsville, 20882 Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest styles, or heart failure. List only one cause on each line. 23a Paul 1. Enter the disease Approximate Interval Between Imm riate Cause (Final disease or condition Onset and Death Physician/ neumonia Medical resulting in death) Examiner wilure pirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attanding physician and I for use as tha buriel-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month pega 2 should ba dateched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this cartificata 2 2 N 1 Yes 2 No To the Hoapital or Attending Physiciem: Within 24 hours effar death.

To the Funeral Director: Affar this cartiflor complataly filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

of Vital

Division

30. Name appliaddress of person who completed cause of death (Item 23a) (Type, Print)

Blanca 31. Date filed (Month, Day, Year)

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UQUSI 2:30 AM MELISSA MICHELLE YOUNG Medical acility Name (if not institution, give street and number) ion of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 218-82-7446 43 1 🗆 M 2 🗶 F MARCH 25,1969 MARYLAND Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 X No MARYLAND CHARLES BRANDYWINE (MALCOLM) 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a UNITED STATES 20613 15125 REGINA AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced Specify: BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 2 YEARS STATE COVERNMENT CLERICAL SUPPORT FAMILY INVESTIGATOR traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ CECELIA LILLIAN QUEEN YOUNG WILBERT LEROY YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 15135 REGINA AVENUE, BRANDYWINE, MARYLAND 20613 CYNTHIA D. HILL / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HERTTAGE MEMORIAL CEMETERY SEPT. 8,2012 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service License THORNTON FUNERAL HOME, P.A LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. Ovarian disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events the burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death

Unknown Month Day Year signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 【 No Yes 2 No Division of Vital or Attending Physician: after death. Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 / No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 069566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Garrett Avenue, La Plata, Michel, MD 31. Date filed (Month, Day, 32. Registrar's Signature State 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar			Certifica	te of D	Death			Reg. No			
	-	- 10	Decedent's Name (First, Middle, L.)	ast)						2. Date of De	eath		3. Time o	f Death
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	and shov	ē	10a. State 10b. County		10c. City, Town	or Location							10d. Inside C	ity Limits
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 11,15-22 per fh g932 10-1-12 vt
State of Maryland 7 Department of Health and Mental Hygiene
amend #9,10g,17618 Per FH g932 10/09/2012 JH

Certificate of Death

Reg. No. 20 1 2 Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Cholanan Medical reptember 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore 5. Social Security Numberunk 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Unit. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours **Director** 1 M 2 D F 62 1950 Nigeria Usual Residence of Decedent Feb permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Evaniner must be notified at ones, once. Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant of Health and Mental Hyglene. ant If item 27 is marked other then "natural", or items 23a or 28a-7 show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Randallstown MD Ballimore 1 Yes 2 Tho 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21133 Funeral 3910 Tiverton Rd. Nigeria 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status unk 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12)
unk 12th College (1-4 or 5+) unk Church Organist Be 17. Father's Name (First, Middle, Last) unk Fawole Ayodeji Fadiole 18. Mother's Name (First, Middle, Maiden Surname) မှ **Alake** Alakg 19a. leformant's Name/Relationship/(Type Print)
SUSAN SOMITHE PASTOR
JOHNS HOPKINS HOSPITA 19b. Maiifi 903es Asire i core m Ruardra Randarbles towns, Md. zip 2dd 36 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 x Burial 2 Cremation 3 Removal from State 5 D Other (Specify) in State 4 Donation 9-29-12 Zion Cemetery Lansdowne, Md. 21. Signature of Rungfal Service Litensee Anatomy Board Reisterstown Baltimore, MD 22. Name and Address of Facility State A Chatman Harris FH. 5240 Rd. 21201 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ischemic cardiomyopathy Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use es the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{Nursing Home}} \) 1 \(5 \text{\text{\text{Nesidence}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{\text{Other}}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\text{Other}} \) 1 \(6 \text{\te 1 ☐ Yes 2 🖾 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Z. Jaan, MD elisoni C 25-00 Eptember 15, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allison L 1800 Tsao orleans 32. Registrar's Signatural 31. Date filed (Month, Day, Year) State 4 2012 SEP Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ 9:50 Thelma Violet Allen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Good Samaritan Hospita Baltimore 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Jamonto ay, 1932 ORTO) Director 290-28-1045 80 1 ☐ M 2 🛣 F permit. Paga 1 and 2 should be fliad within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 St Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 N. Lakewood Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry $\, unk \,$ (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) office work 12 å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Jefferson Stumbo Velva Marie Mullenix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1924 Root Lane; Tucson, AZ 85705 Wilma Faye Ferry - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dan Yel A. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attanding physician and for usa as the burlai-transi Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) baen signad by tha s should be datached Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this cartificate has I filled in by the funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 houndly the Fune complately fl 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 09.18,2012 ass of person who completed cause of death (Item 23a) (Type, Print)

Mauling Zhang 560/ Loch Raven Blvd, Baltimore

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RONDA Mod 9:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Huspita Battimore usedale If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign **Funeral** 212-82-8455 **Director** 1 M 2 X F 48 Yrs. MD10-01-1963 or 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director be notified MD BALTIMORE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a o Funeral 37 SOLAR CIRCLE 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: BIACK "natural", 3 Widowed 4 Divorced Completed Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, KENNEDY KREIGER College (1-4 or 5+) Elementary/Secondary (0-12) f Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N TEACHER INSTITUTE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GEORGE Page 1 and 2 should be ALLEN MATTHEWS Ε. ALMA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER Ashby Grove . HAYMARKET, VA. 20169 HOLDEN If item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: It any injury or Cemetery BALTIMORE, MD 9-26-12 4 Donation 5 Other (Specify) 22. Name and Address of Facility V AUGHN GREENE FUNERAL SCVS . Signature of Euneral Service Licensee YORK ROAD. BATTIMORE, MO. 21212 1401553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus non each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Que to for sels nonesquence of cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No be detached for Day Year Pregnant at time of death 1 Yes 2 D Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy 1 Yes 2 No Yes the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation
6 Could not be **Director**: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 44604 pleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 0235 M omas ASTRO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center alen Burnie, mo Anne Arundo 21061 If Under 1 Year I If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours September 13, 1989 **Director** 29 1 XX 2 F Mexico item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 Mexico 57 Glen Ridge Ridge Rd Apt#6319 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Maryland 21215-0036 1 Xes 2 ☐ No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: Hispanic Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any fnjury or other traumatic event, the Medic once. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Mechanic</u> Engineering Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tomas Perez Julia Castro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Glen Ridge RD, GLen Burnie, MD 21061 Hector Alejandro Castro Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Sept 20, 2012 Catonsville, MD 21, Sign (ure of Funeral Service Liter) 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 Fink M01148 Gregor 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 2 No g Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 W No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide n 24 hours and the Funeral Director. After a Funeral Director of the fur 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or buestigation in manufacture in the cause of examination and/or buestigation in manufacture. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of the Cause (s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 00060910 hand DIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHIRAG CHAUDHARI 301 GLEN BURNE, MO 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

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Maritza Elizabeti				of Marylai	nd / Dep		of Hea	alth and		, ,	gible. eg. No.	201	2 3039
Physicia Medical Exami	in/	1. Decedent's Name (First,							-	2. Date of Deat Month August 24	th	Year	3. Time of Death 2040 hrs
jesuiçai Exami	ilei	MARITZA ELI 4a. Facility Name (if not ins 5605 Kennedy Sti	titution, give	street and num		JA		, Town, or Lerdale	ocation of Dea		4c. C	ounty of Deat	h
Funeral Director		5. Social Security Number	6. S ex			last birthday)	If Un Mon	ider 1 Year					rthplace (State or gn F1 Salvade
Director	}	NONE Usual Residence of Decede		M 2∑F		32 _Y	rs.	2,0		Octobe	r 28	Co	ountry) Dailyau
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e Maryl or 28a-1	Director	10e. Street and Number		" 000				ip Code				of What Cou	intry?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral [5605 KENNED 11. Marital Status 1 Never Married 2		# 203 12. Was Dece Armed For 1 Yes			Vas Dece		panic Origin? (Mexican, Puer	Specify Yes or No-		Race - Amer White, etc.	ican Indian, Black,
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72 hour	eted	15. Decedent's Education Elementary/Secondary (0)		College (1-4					on (Give kind o DO NOT use r		16b. Kind	d of Business/	Industry
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215- be filed atal Hyg che ot	BeC	17. Fathers Name (First, M		OBERTO	ABARCA	A GIL				ne (First, Middle, N RIVAS AL		rname)	
D 21 should I and Mer 7 is man	ဥ	19a. Informant's Name/Rela		pe, Print) (de	etectiv	rud)				r Rural Route Num Palmer Pa			
e, M 1 and 2 Health item 2	ŀ	20a. Method of Disposition		1		Place of Disponentary or o	osition (Na	ame of cem		Date Fa		ation - City or	
Baltimore, MD 21215-0036 oernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medical		1 Burial 2 Crem 4 Donation 5 Oth	er Specify:			ESPIN	0			pt/ 15/1		l Salva acateco	
Balt permit Depart Impor		21. Signature of Funeral S	Vice Lipense		CC03	140				nta Cruz ,Washing			
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Examiner		Immediate Cause (Final dis or condition resulting in dea		harp Force ue to (or as a c		of):							Death
	-G	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a c	onsequence o	of):							
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Division of Vital Records, P.O. Box 68760, note Hospital or Attending Physician: The law requires that the death certificate beawithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burit		3b. Was decedent pregname past 12 months? 1 Yes 2 No 9 ✓		1 Live birt	h nt at time of de	2 🔲 F	etal death Other <i>(Spe</i>		Ectopic pregi	nancy			Day Year
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tal Recion: The certificate ector, page	ပ္ပို	25. Was case referred to me	dical					26.Place o	of Death (Check	1 ✓ Yes 2 k only one)	No No	1 🗸 Ye	es 2 No
F Vitz Physicia or this ce	2 B	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hos		atient 2	ER/Outpatier				ing Home 5 F		C	Scene
on of ending Pl ath. or: After the funera	Ę	1 Natural 5	Pending	28a. Date of FOUND: Aug 24, 20	ay,Year)	FOUND: 2030 hrs	ii ijui y	28c. Injury 1 Ye	es 2 No	28d. Describe he Subject stab			
Division of Neither the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6	Investigation Could not be determined	28e. Place		ome, farm, str	eet, factor	y, office bui	ilding, etc.	28f. Location (Stor Town, Stor 5605 Kennedy			ral Route Number, City erdale, MD
To the Hosy vithin 24 hc To the Fun completely i	70	(and an arm)	Examiner: 0		examination a					d due to the cause at the time, date a			
	Σ	29b. Signature and title of co	ertifier	1/5		-	29	O.C.M				signed (Moi	nth, Day, Year)
	-	30. Name and address of pe	rson who cor	16	of death (Item	23a)				<u> </u>			
	1/2	Melissa Brassell, Manth, Day, Y			cal Examii		V. Baltii	more Str	eet, Baltim	ore, MD 2122	3		
Sta Registi	-	SEP 2 4	2012	Buch	n b	bar	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per ANA BD G932 10/04/2012JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 13 Richard Lee Bennett 2:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care, Inc. Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) 1939 Days Hours Mary Land Director 42-28-2950 1 € M 2 🗆 F 73 Usual Residence of Decede permit. Page 1 end 2 should be filed within 72 hours after death with the Manyland Dependruent of Health end Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or items 23e or 28e-f show enter injury or other treumetic event, the Manical Example to the number once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MT Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue #602 21211 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

Yes 2 2 1 þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Divorced Completed Specify: Black rear or Dates. 1958-78 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) medical records healthcare Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Gladys Jean Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Bennett - wire 3939 Roland Ave #602; Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Serv 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jancrean Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 🗌 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident 2 🗌 No Investigation Suicide 6 Could not be Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) taron HARVES MOZIMOT 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:00 PM Marzella Brown Sept. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country)
N.C. Hours. Director 71 <u> 245-68-3492</u> 1 M 2 X F 9-16-41 Vre Usual Residence of Deceder Show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits D.C. n/a Washington 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20019 U.S.A. 3508 Minnesota Ave. S.E. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1X Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working filed within 72 all Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Post Office 12th Clerk Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ၉ William P. Smith Katie Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Columbia Ave., Ramseur, N.C. 27316 Ronnie Brown/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9/29/12 Ramseur, N.C. Oakland-McCrary 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22, Name and Address of Facility Hackett's Funeral Chapel, th W. Hacket 814- Upshur Street, NW Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Years Cervical Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as the IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 🔀 No Month eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f g | I Inknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypercalcemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 ☐ Yes 2 X No ည 1XXnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Suresh K. Gupta,

SEP 2 4 2012

31. Date filed (Month, Day, Year)

29c. License number

D32332

9801 Georgia Ave. S.S. Md.

29d. Date signed (Month, Day, Year) 9/21/12

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pamela Boyd		1- For State Registrar	State	e of Maryla		artment of	Health and Death	Mental I		Reg. No. 20	12 3039	
Physicia Medical Examin	n/	1. Decedent's Name (Fi Pamela A	nnett	e Boyd					2. Date of Dea		3. Time of Death 0945 hrs	
d		4a. Facility Name (if not 5700 The Alam			nber)	1	tb. City, Town, or L Baltimore	ocation of Dear	h 4c. County of Death N/A			
Funeral Director	- 1	5. Social Security Numb 219-76-58	80 1	Sex M 2 Kg	7. Age (In yrs. I 47	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24Hr Hours Mi	_		9. Birthplace (State or Foreign Country) MD	
and show any acc.	5		cedent County N/A		10c. City	Town or Locati	on ltimore				10d. Inside City Limits 1 Yes 2 No	
	I Director	10e. Street and Number 5700 The			'		10f. Zip Code 212	39		U.S.		
after death wi	by Funeral		4 Divorce	Armed For 1 Yes ed If Yes, Give Year or Dates:	2 X No	If Ye	s Decedent of Hispa es, specify Cuban, I Yes 2 🛣 No	Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14. Race - A White, e Specify:		
C 3	mpleted	15. Decedent's Educate Elementary/Secondari 12th Grad	ny (0-12) de	College (1-		during mo	i's Usual Occupationst of working life. Do	OO NOT use ref		16b. Kind of Busin	,	
De fi	å	17. Father's Name (First Leroy J] 19a. Informant's Name/F	Boyd			140		Bre	nda J.	Maiden Surname) Macer		
MD ad 2 sho alth and in 27 is aumati		Clifton 1	Macer	(uncle)		7407	Thames	River	Dr.,	mber, City or Town, S Hanover	, MD 21144	
Baltimore, permit. Pages I ar Department of Hee Important: If the injury or other tr		1 Burial 2 C 4 Donation 5 21 Sharature of Funeral	remation 3 Other Specif	y: 0	m State	rematory or oth	er place) Cremato	ory 09/	allia	Baltin	more,MD	
ញ់ ឱ្យីឮឆ្នាំ Physician /Medical	+	23a. Part I. Enter the dis failure. List only on	ease, or com	prisetions that care	used the death.	\bigcirc \angle $ $	40 N. P	TITOU	Ave.,	Baitimor	Approximate Interval Between Onset and	
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		Sequentially list condition if any, leading to immedicause. Enter Underlying (Disease or injury that in events resulting in death	iate g Cause iitiated	Due to (or as a c								
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	3	Part II. Other significant Cocaine U			_ =========	sulting in the un	derlying cause give	en in Part I.	1 Yes	2 No 3	e to the cause of death? Probably 4 Unknown	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the star after death. at Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detabled in by the funeral director, page 2 should be detabled.		25. Was case referred to	medical				26 Place of	Death (Check	24a. Was a autop perfor	sy prior med? deat		
f Vital Physician or this certi	ă۱	examiner?		Hospital: 1 Inp	patient 2	ER/Outpatient				Residence 6 🗸 0	ther: Scene	
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Division O To the Hospital or Attending Whith 24 hours after death To the Funeral Director: After completely filled in by the fune		3 Suicide 6 Homicide	Could not determine	ed (Specify)	Fd:Res	sidence	, factory, office build		or Town, Si	tate)5700 The Baltimore	<u>,MD.</u>	
To the Hos within 24 hr To the Fun completely	II CAII CAI	Check only Certi	cal Examine	r:On the best of and manner sta	examination an	e, death occurre d/or investigatio	ed at the time, date on, in my opinion, de 29c. License n	eath occurred a	due to the cause t the time, date a	e(s) and manner as and place, and due to	o the cause(s)	
a		inc	٠ -			20.1	O.C.M.I			29d. Date signed (
Stat	d	31. Date filed.(Month, Da	ssistant M	ledical Exami		V. Baltimore	Street, Baltim	ore, MD 21	223			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 00:40AM 2012 TYWIN ENDME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 If Under 1 Year | If Under 24 Hrs. IN INDA. Age (In yrs. 8. Date of Birth Month, Day 9. Birthplace (State or Foreign **Funeral** Days Months Hours 12M 20F Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 des 2 No be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with ō Funeral 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 No 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced "natural" Completed Department of Health and Mental Hygiene important: If Item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Segandary (0-12) College (1-4or 5+) MAINTENACE of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZOUN-WIFE 20b. Place of Disposition (cemetery, crematory 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liminse 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease or condition resulting in death) CARCINOMA HEPATOCELLULAR Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 □Pending investigation Injury 1. Natural within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier PHYSICIAN

and manner stated

29c. License number 00064533

Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

09-19-2012 GERLATTLIC CTTZ MEBREW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE AJANI MD 2434 W.BELVEDERE AVENUE BAUTMORE M) 2/215 ABATUMDE

31. Date filed (Month, Day, Year) SEP 2 4 2012

Registrar's Signature

		Z	AMEND 25,27,28A-	se Type or	Print in	Black Ir	ndelible Inl	k. Ensi	ure All Copi	es Ar	e Legik	ole.	
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	Examir	er	4a. Facility Name (if not institution,				4b. City, Town, or			4	c. County of		
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	and show	P	10a. State 10b. County		10c. C	ty, Town or Lo	cation	<u> </u>	modecre	10,1	747		Od. Inside City Limits
	Maryla 28a-f	Director	Maryland Mon	tgomery			Si	lver s	Spring				1 ☐ Yes 2 🂢 No
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15-	within 72 hours after death with the Maryland gene. gene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	(Specify only highe	t's Education st grade completed)		(Give I	lent's Usual Occupa kind of work done o O NOT use retired)		of working	16b. l	Kind of Busir	ness/Ind	ustry
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Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hea Important: If item any injury or other	- 1	4 Donation 5 Other (S	pecify)	Ft.	Linco	ln Cremai	tory (08/06/2012				
Bal	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Li	censee -	/ MC	1564 22	. Name and Addres	s of Facility	Hines-Ri	raldi	Fune	ral	Home, Inc.
			23a. Part 1. Enter the disease, or	complications that ca	used the dea						ол Ѕрл	\neg	MD 20904 Approximate
~ t.	Physician/	()	shock, or heart failure. List or Immediate Cause (Final disease or condition	-		hdural	Hematoma					- 1	Interval Between Onset and Death
-	Medical Examiner		resulting in death)		r as a conseq		Tremocoma					+	
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o uc	nding ath. r: After	icate	1 Noturel 5 Pending 2 XAccident Investig.	(Month	Day, Year)	injury 2 FD 3:0	work?		28d. Describe PROBAI				
visio	rr Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ot be 28e. Place o		me, farm, stre	et, factory, office					CARE	WHEATON SPRING, MD
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 L Medical Ex	Physician: To the bes aminer: On the basis Nurse Practitioner: T	of examinatio	n and/or investi	gation, in my opinior	n, death occ	urred at the time, date	and place	and due to	the caus	e(s) and manner stated.
	vithii To th		29b. Signature and title of certifier	001	الما	2 0	29c. License				te signed (M		
	(A)		• // 0	1	-	٠- ٢		D45	471	A	ugust	02,	2012
			30. Name and address of person w Yeheyis Negussi					Sili	ver Spring	Ma	rulane	1 20	910
	Stat	е	31. Date filed (Month Pay Year)	2010 32. Keg	istrar's Signa	ture.		, Jacob	or sprung	y MICC	cycum	. 20	710
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12-07057 Russell Coope Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ssell Cooper		1- For State	ate of Maryl		artment of		and	Menta	al Hyg	giene	Pos N		012	3040
Physici	an/	1. Decedent's Name (First, Middle	e,Last)						2	. Date of D				Time of Death
edical Exam	iner	Russell Cooper								Month Septem		, 2012		2249 hrs
<i>)</i>		4a. Facility Name (if not institution 4104 Barrington Road	n, give street and n	umber)	41	o. City, Tov Baltimo		ocation of	Death		ľ	4c. County o	f Death	
Funeral		Social Security Number unit	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under	24Hrs.	8. Date of	Birth (MI	M/DD/YYYY)	9. Birthpl	ace (State or _unk
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Russell Coope	r - son									, MD :		
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Page ment c		4 Donation 5 ₩Other Spo	in sta	te Or	n-Site C				9/24	/2012	2 B	altimo	ore,M	D
Balt bermit. Depart mpor njury		21. Signature of Funeral Service I Daniel	icens aylor		22. Na Joş	me and Ad eph H	. Bro	of Facility	SF	teran geran	Home	PA 24	WN. I	ultonAve.
Physician		23a. Part I. Enter the disease, of	complications that	caused the death	h. Do not enter the	e mode of o	ba dying, sı	L C L III C uch as car	ore :	espiratory	a⊥t1 arrest, s	more, Nock, of hea	40,4 1	Approximate Interval
/Medical		failure. List only one cause of	on each line.		vascular Dise									Between Onset and Death
raminer		Immediate Cause (Final disease or condition resulting in death)		a consequence		430			•					
Noncomme.	Ļ	Sequentially list conditions	b		-0.									
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.	a consequence (oi).									
ed	Exar	events resulting in death) Last	Due to (or as	a consequence	of):									
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60, ate be ex hysician e burial		IF FEMALE:	23c. If yes,	-12 SM outcome of pre	gnancy				_		2	3d. Date of	delivery	
ox 6876(eath certificate attending phyron as the b	ian/I	23b. Was decedent pregnant in the past 12 months?	I LIVE		- =	al death	3	Ectopic p	pregnand	су		Month	Day	Year
Sox 6 leath cer e attendi for use	Physician/M	1 Yes 2 No 9 Unki	do ob		5 Oth	er (Specif)	<i>'</i>)							
tribe d		Part II. Other significant condition			resulting in the un	derlying ca	ause giv	en in Part	t I.	23e. Die	d tobacc	o use contrit	oute to the	cause of death?
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Cecc The law ate har	mo										rformed's 2		eath? Yes	2 No
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Division of Vital Records, rat or Attending Physician: The law require is after dearth. al Director: After this certificate has been sided in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could 4 Homicide determ	not be		iomo, iaim, sa cor	, lactory, o	moc bui	nuing, ctc.	.	or Town		and Hambo	or realer	Nodic Humber, Oily
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier 1 Certifying Ph	ysician: To-the be	est of my knowled	dge, death occurre	ed at the tir	ne, date	e and plac	e, and du	ue to the ca	ause(s) a	and manner	as stated.	
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			(D.C.M	l.E.			Se	eptember	19, 201	2
OCME		30. Name and address of person wary G. Ripple MD.	Donuty Chief			W. Baltir	nore!	Street F	Baltimo	ore, MD	21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 25,27,28A-F, PER ME 6931 9/20/12 TRT state of Maryland 7 Department of Health and Mental Hygiene Amend 28e-f, per me, 8942,8-16-13 sm Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Frances Carpenter 2012 17. Α August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Future Care North Point Dundalk If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. 1<u>918</u> october 26, 1 M 2 X F Months Hours Mary land 213-14-9184 Director 93 Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3406 Yorkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within 12 Years Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve and Mental F is marked o ဂ္ Gabriel Forte Mary Capezio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Yorkway, Dundalk, Maryland 21222 James Carpenter Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 20 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holy Redeemer Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner atherosebran Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due door as a consequence of: TION APPROVED BY resulting in death) Last CERTIFICA Physician/Medical The law requires that the death certificate be d. Depression 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, bilateral hip fractive 1 Yes 2 No 3 Probably 4 Unknown Urinary tract intechs 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?

1 XYes 2 100 Hospital: Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 🔀 No 1 Natural 5 Pending injury 2 X Accident JULY, 2012 UNK Investigation PROBABLE FALL within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1046 Old North Point Rd. 3406 YORKWAY BUNDALK, MD Balto, MD determined HOME Nursing Home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Shushil Sagar, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Weltham Parkville - MD MO 31. Date filed (Month, Da 32. Registrat's Signature State Registrar

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		Physicia Medio		JAMES	CHANDLE							Month Septem	bej	06 2	Year 012	9:35 PM
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ì		Funeral		5. Social Security Number	6. Sex 7. A	nge (In yrs. la	ast birthday)	If Und	er 1 Year_	If Under Hours		8. Date of Bi		T		place (State or Foreign
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	~	nysician/ Medical		disease or condition resulting in death)	a. Due to (or as	MMUN1		acqu	<i>nisee</i>	pr	1041	monia			4	Onset and Death 2 Weeks
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CH/	or Att	after de Directo	Certificate:	3 Suicide 6 Could in 4 Homicide determine	inod 28e. Place of In	njury - At hoi tc. <i>(Specify)</i>	me, farm, str	reet, factor	ry, office			28f. Location (City or To			or Rura	l Route Number,
	ospital	hours uneral aly fillec	Medical	29a. Certifier 1 Certifying	Physician: To the best of	of my knowle	edge, death	occurred a	at the time	, date and	place, ar	nd due to the c	ause(s)	and manne	r as stat	ed.
	the H	Within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,	Me	(Check 2 ☐ Medical E only one) 3 ☐ Certifying 29b. Signature and title of certifier	xaminer: On the basis of Nurse Practitioner: To t	the best of m	ly knowledge	, death oc	my opinio curred at the c. License	ne time, dat	e and pla	ce, and due to	the caus	se(s) and ma	inner as	stated.
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4		(at)		30. Name and address of person v	, ,			Print)				0				21229
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		Registra	-	SEY 2 4 20	JIZ proju	/J.	ure for	F. Carlotte								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (Physician/ 5,25 6 Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Med 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Country) Months Davs Hours Min. (Month, Day, **Director** Usual Residence of Decedent Show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Funeral Director 1 Yes 2 No timorp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C arlene Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 101 E. North AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, ratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a d sequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-transi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: Certificate: To 1 🗌 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 \(\square\) Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

d address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's

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State of Maryland / Department of Health and Mental Hygiene for State Registrar 30404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year VINCENT SALVATORE CUSIMANO SEPTEMBER 10:00 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5126 BRIGHTLEAF COURT BALTIMORE ROSEDALE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) MARYLAND 218-26-8049 81 Director Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c, City, Town or Location Director MD BALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5126 BRIGHTLEAF COURT 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
Yes 2 No Black, White, etc. 1 Never Married 2X Married ò Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 1948 - 50 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) POLICE OFFICER BALTIMORE CITY Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 입 VINCENT CUSIMANO COSIMINI . ANNARINO traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other trau ANNE CUSIMANO/WIFE CT5126 BRIGHTLEAF ROSEDALE, MD 21237 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-27-12 GARDENS OF FAITH BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licer 1211 CHESACO AVEROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Sureide(Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or linjury that in the cause (Disease). Examine Due to for as a consequence of: the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 for use as 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of qeath? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an page 2 autopsy performe Yes 2 has funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital: Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at iniury 1 🔲 Natural 5 Pending 1 Yes 09/22/2012 2 No gunshot 1000 A Accident Investigation To the Hospital or Attend within 24 hours after deatl To the Funeral Director.. 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Jown, State) 5726 Bright 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined vion Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) O of death (Item 23a) (Type, Print) th, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Kelly G. Degracia

		1- For State Registrar		Certif	ficate of	Death		F	Reg. No.	112 3040
Physici		Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath	3. Time of Death
ledical Exam	iner	KELLY G. DEGRACIA							Pay Year 18, 2012	0305 nrs
		4a. Facility Name (if not institution, 3603 North Canal Stree			4	b. City, Town, o		Death	4c. County o	
						Ocean City			Worcest	
Funeral Director				e (In yrs. last	birthday)	If Under 1 Ye		24Hrs. 8. Date of Bi	rth(MM/DD/YYYY)	Birthplace (State or Foreign
Director			M 2 XX F	41	Yrs.		7.00.0	JUNE 4,	1971	Country) MN
any		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location					10d. Inside City Limits
A			NOTE TO			""				1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	rector	CA LOS A 10e. Street and Number	NGELES	SANIA	MONICA	10f 7in Code			0.000	AA
e Mar or 28,	ě	22.00				10f. Zip Code			log. Citizen of Wh	at Country?
ith th	a Di	16 LATIMER RD. 11. Marital Status	Tao Mar Breadest	ri- II O	140.14/	9040			USA	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	Never Married 2 Marr	12. Was Decedent ied Armed Forces?					n? (Specify Yes or No Puerto Rican, etc.)	0- 14. Race White	- American Indian, Black, , etc.
ter de		3 Widowed 4 XXDivore	1 Yes 2	X No	- 1 - 1 - 1	Yes 2XX N	o s <i>pecify:</i>		Specify:	WILTE
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5-00 led will Hygier of the M	Ö	17. Father's Name (First, Middle, La	ast)				18.Mother's	Name (First, Middle,		
2121! Ild be fil Mental H narked event, t	Be	MARSHALL L. GIBBS					ANN W	INFREY		
MD 21215-0036 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than " marite event, the Medical marite event, the Medical	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	et and Numbe	er or Rural Route Nur	mber, City or Town	, State, Zip Code)
- 0 = a = 1		ANN WINFREY BROWN	мотн					TX 78602		
ore, M ses I and 2 of Health If item 2 ther traum		20a. Method of Disposition 1 Burial 2 XX Cremation	3 XXRemoval from Sta		e of Disposit natory or other	ion (Name of co er place)	emetery,	Date	20c. Location -	City or Town, State
imore, MD 2 Pages I and 2 shoul ment of Health and N ant: If item 27 is n or other traumatic		4 Donation 5 Other Spec			OL MORTI	JARY CREM	ATORY	SEPT 24,2012	AUSTIN,	TX
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	ΙĐ	21. Simal re of Funeral Service L		1	22. Na	me and Addres	s of Facility	DA T/A MA	DVI AND MOD	TUARY SUPPORT
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						
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760, icate be g physici the buri	Jed	IF FEMALE:	23c. If yes, outcom	e of pregnanc	rv				23d. Date of d	lelivezy
rtifica		23b. Was decedent pregnant in the past 12 months?	1 Live birth	o or program		Ideath 3	Ectopic p	regnancy	Month	Day Year
Box 687 he death certific the attending	iğ.	1 Yes 2 No 9 ✔ Unkno	4 Pregnant at t	ime of death	5 Othe	r (Specify)				
be de y the	Physician		3 UINIOWII	h. A	tion in the con-	dank inn na	-b t- D-41	00- Bida		
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cian:	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien					heck only one)		
Physical direction	္	1 ✓ Yes 2 No 27. Manner of Death			/Outpatient			lursing Home 5	<u></u> -	
ding O	ᇹ	1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ar)	b. Time of Inji		ıryatWork? Yes 2. x Nı		now injury occurred	
SiO Atten dead cetor:	E.	2 Accident Investig	ation 1d 9-18		d03:00	јащ				
Division of Vital Records, P.O. at or Attending Physician: The law requires that it is after cleath. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	Certification:	3 Suicide 6 X Could n	ot be ned (Specify) P	arking		ractory, ornice i	building, etc.	or Town, S	tate) 3603 No	or Rural Route Number, City
fospit I hour uners		29a. Certifier				ما معاد ما الم	-1 1-1		ity,MD.	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	edical		ician: To the best of my ner:On the basis of exam							
To vit	Mec	29b. Signature and title of certifier	and manner stated.	^		29c. Licens				(Month, Day, Year)
		MI A	(11/11)	3		O.C.	M.E.		September	
		30. Name and address of person wh	o completed cause of de	ath (Item 23a	1)				<u> </u>	·
			Assistant Medical		•	Baltimore S	Street, Balt	imore, MD 2122	3	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar		/					
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Physic Medical Exam						_	2. Date of Dea	ath Day Year	3. Time of Death
)		4a. Facility Name (if not institution	_)	4b. City. Town	n, or Location of De	Septemb	er 20, 2012	1517 hrs
,		Franklin Square Hosp			Rosedale		, and	Reg. No. 2. Date of Death Month Day September 20, 2012 4c. County of Death Baltimore Cou 8. Date of Birth(MM/DD/YYYY) 9. Birt Foreig Cou 10g. Citizen of What Coun USA city Yes or No- tican, etc.) 14. Race - Americ White, etc. Specify: Whi rk done dican, etc.) 16b. Kind of Business/Ind. Ste: I Mill First, Middle, Maiden Surname) Ce Taylor ral Route Number, City or Town, State, el Air, Maryland 2 20c. Location - City or Town autopsy performed? 1 Home P.A. Venue Essex, Maryl aspiratory arrest, shock, or heart 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day 23d. Date of delivery Month Day	
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Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Cod	e	1	0g. Citizen of What	
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21215-0036 and be filed within 7 Mental Hygiene. marked uther than c event, the Medica	Be C	William Carrol						,	
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Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If titem 27 is marked nith injury or nther traumatic event, the I		1 Burial 2 Cremation	3 Removal from Sta	te cremato	Disposition (Name of ry or other place)			1	•
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Ba Perm Depa Injur		$ I I V \cap I I I I$	kousko		Bruzdzin	ess of Facility ISK i Fune	ral Home	P.A.	- 1 - 3 04004
Physician			complications that caused	the death. Do not	enter the mode of dyir	ng, such as cardia	or respiratory arre	est, shock, or heart	Approximate Interval
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60, nte be exe hysician a	Medical	UNPENDED	AMENDED						
. 68760, certificate be executed anding physician and ise as the bunial - transi	I/M	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnancy	Fetal death	B Ectopic prea	nanov		
Box 687 death certifics the attending p	Physician/N	past 12 months?	4 Pregnant at t	ime of death 5	Other (Specify)	ctopic preg	nancy	Wiorith	Day Year
by the ched fiched f	Ph	Part II. Other significant condition	9 Unknown	but not resulting i	n the underlying cause	civen in Part I	. 220 Did tol	naces use seets but	1.1
Vital Records, P.O. Box 6876 bysician: The law requires that the death certificathis certificate has been signed by the attending phildrector, page 2 should be detached for use as the	d b			- Line () out in ig	in the directlying cause	s given in rait i.			
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Physic r this or		1 ✓ Yes 2 No		t 2 🗹 ER/Outp					ner:
Division of Vital Records, for the Hospital or dateoding Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been significately filled in by the funeral director, page 2 should be	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	gation	1336 h	rs 1	ury at Work? Yes 2 ✓ No	Driver of mot	orcycle struck a	
houn hou		3 Suicide 6 Could 4 Homicide determ	(Specify) Loca	I Street	n, street, factory, office		or Town, Sta Orems Road at	ate) t Entrance Drive, M	fiddle River, MD
To the Hospital within 24 hours To the Funeral completely filled	edica	one) 2 Medicai Exami	sician: To the best of my iner: On the basis of exami and manner stated.	knowledge, death nation and/or inve	occurred at the time, o	date and place, an on, death occurred	d due to the cause at the time, date a	(s) and manner as st nd place, and due to	ated, the cause(s)
	2	29b. Signature and title of certifier	1 8	1		se number			
	-	30. Name and address of person w	to completed source of de-	ath (Hom 22)	0.0	.M.E.		September 21,	2012
		Zabiullah Ali, M.D. As	no completed cause of dea ssistant Medical Exa		W. Baltimore Str	eet, Baltimore	, MD 21223		
Sta Regista		31. Date filed (Month, Day, Year)	2. Registrar's	1 1	Kal				
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		_	For	State of M	1arylan	d / Depa	artment of	f Health	and N	/lental Hy	giene	9	_	4
			State Registrar			Cer	tificate o	f Death			Reg. No	.201	2	30407
	Physicia Medic		1. Decedent's Name (First, Middle MICHAEL	, Last) ANGELO	De	PASQU.	ALE, J	R		2. Date of De Month SEPTEMBE		i, 201ž	ear	3. Time of Death 3:50 A M
	Examin		4a. Facility Name (if not institution, GILCHRIST HC	give street and number) SPICE CEN	TER		4b. City, Town	, or Location OWSON	of Death			County of I		
	Funeral Director		5. Social Security Number 218-26-4566 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. la	ast birthday) 1 Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Bir (Month, Da 12-14	th ry, Year) - 19:	30 M	Birthp Count AR	olace (State or Foreign try) YLAND
	Maryland Ba-f shov tified at	rector	MD BA	ALTIMORE	10c. City	y, Town or Loc	eation MIDDLE	RIVE	ER				1	0d. Inside City Limits 1 ☐ Yes 2X No
	s 23a or 2 s ust be no	Funeral Director	10e. Street and Number 1201 APPARIT	ON LANE			10f. Zip Code		220		10g. Ci	itizen of Wha	t Coun	•
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumetic event, the Marical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ied 1 ☐ Yes 2 X If Yes, Give Year or Dates.	2	"	Vas Decedent o Yes, specify Cu	ıban, Mexica	an, Puerto	cify Yes or No- Rican, etc.)		14. Race - / Black, V Specify:	White, e	
21215-0036	hin 72 hoi ne. than "nat	Be Completed by	(Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4 or	5+)	(Give F life. D	lent's Usual Occ kind of work don O NOT use retire	e during mo ed)			16b. K	Kind of Busin		·
2	Hygie ther	Se C	12 17. Father's Name (First, Middle, L	4		CO	RRECTI				<u>L.</u>		ESS	SUP
Maryland	uld be file Mental F arked o	2	MICHAEL AND	GELO DeP	ASQU	ALE,	SR.		her's Name RRIE	e (First, Middle,		Sumame) RKS		
, Mar	ind 2 shot fealth and im 27 is n		19a. Informant's Name/Relationsh CLAUDIA DePAS		'E	19b. Mailin 1201	g Address (Stre APPAR	et and Numl	ber or Rura ILAN	NE MI	r, City or DDL:	r Town, State ERIV	ER,	code)21220 , MD
Baltimore,	Page 1 a ment of h tent: If ite iury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from Stat pecify)	e C	emetery, crem	sition (Name of natory or other p REMATO		9-22	Date 2 – 1 2		ocation - Cit TONSV	-	wn, State LE, MD
Ball	permit Depart Import eny in		21. Signature of Funeral Service L	icensee	\geq			fress of Faci				ALE F LE, M		ERAL HOME 21237
	Pnysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each lir	ne.		r the mode of d	ying, such a	s cardiac c	or respiratory ar	rest,	-		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a Due th (or as	a chnsequ								+	
	rted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequ	ence of):								
0	e be executed ysician and le burial-transit	ह्न	resulting in death) Last	Due to (or as	a consequ	ence of):			-					
876	tificet ng ph as th	Med	IF FEMALE:											
. Box 6876(Hospitel or Attending Physician: The law requires that the death certificete be executed 24 hours after death. Funerel Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 ∐ Feta at time of d	II death 3 🗆	Ectopic pregna Other (specify)					23d. Date of Month		ery Day Year
ls, P.O.	requires that the der been signed by the s should be detached	ed by P	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying cause	given in Par	t I.	23e. Did to				e cause of death?
Records,	sician: The law req certificate has bee lirector, page 2 sho	Completed by								24a. Was auto perfo	psy ormed?	prior deat	to con	osy findings available inpletion of cause of
<u>=</u>	an: T tifica tor, p	0	25. Was case referred to medical				26.	Place of De	ath (Check	1 Yes	2 X N	0 1⊔	Yes :	2 No
of Vital	hysician: nis certific I director,	10 B	examiner? 1 Yes 2 No	Hospital:	tient 2	ER/Outpatien	10	thor		me 5 ☐ Resid	dence F	Other/S	pecify	HOSPICE
on of	nding Ph ath. r: After thi ie funeral	Certificate:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig		ury ay, Year)	28b. Time of injury	28c. In w M 1			28d. Describe h			pecity	Topics
Division	ospitei or Attendi hours after death unerei Director: A ily filled In by the f	Certif	3 Suicide 6 Could in 4 Homicide determine	not be 28e. Place of In	jury - At ho tc. (Specify,	me, farm, stre	et, factory, offic	e		28f. Location (S City or Tow			Rural i	Route Number,
	To the Hospitei or Attenc within 24 hours after deatt To the Funerei Director: completely filled in by the	Medical	(Check 2 L\Medical E	Physician: To the best of xarminer: On the basis of Nurse Practitioner: To t	examination	and/or invest	gation, in my on	inion, death	occurred at	the time date a	and place	and due to	the care	seals) and manner stated
	To the To the Comple		29b. Signature and title of certifier	4	. N	1.7.	29c. Lice	nse number			29d. Da	te signed (M	onth, D	Day, Year)
	2 ly		20. Name and address of person v		death (Item	23a) (Type, P	rint) Sul	to 4	(20)	Ball	rlui	ole.	M	021204
	Stat Registra		31. Date filed (Month, Day, Year) SFP 2. 4 2012		ray's Signat	are and								· · ·

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gertrude Bessie Elgare stember 15, 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 24, 1937 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Maryland 219-26-6120 75 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 28a-f show Injury or other traumatic event, the Medical Evantiner aust be notified at Director Maryland Severn Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 21144 United States 1769 Jacobs Meadow Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify ģ Specify: Black 3 ☐ Widowed 4 🗓 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic mental. College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amv Summervilla Wilbert Elgare ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Morant-Obayan/Daughter 1769 Jacobs Meadow Drive, Severn, Maryland 21144 20b. Place of Disposition (Name of cemeter, crematory or other place)
West Arundel
Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State September 20 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will E. Boner **∕**2M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive Heart Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Ö σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Disecuse 1 Yes 2 No 3 Probably 4 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 □ X 0 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐Yes 2X No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

1 | Yes 2 | 1 | Yes

27. Manner of Death 1 Death

2 Accident

4 ☐ Homicide

3 Suicide

D57531

Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

hisney, n. D. 30. Name and address of per the ho completed cause of death (Item 23a) (Type, Print)

Mahir vegi 8601 Veterans Hwy Sucte 204 mixersville, MD 21108 31. Date filed (Month, Day, Year 32. Registrar's Signature

Registrar

Be

Certification: To

Medical

Director:

Hospital within 24 hours a

To the Funeral [

DHMH 17 Rev 1/2001

			For State	Sta	ate of Ma	aryland		artment <i>tificate</i>			nd Me	ental Hyg	giene Reg. No. 2	012	3040	9
			Registrar 1. Decedent's Name (First, Midd	lle, Last)			06/	lincate	OI De	alli		2. Date of Dea	ith		3. Time of Death	_
	Physicia Medic		Ralph John 1									Septem	ber ^{ay} 19	9, 201	2 2:00 A	Л
	Examin	er	4a. Facility Name (if not institution 339 Sassafras	n, give street ar Road	nd number)			4b. City, To	own, or Lo		Death		4c. Cou Ba	unty of Deatl	te	
	Funeral Director	0	5. Social Security Number 219–26–2999 Usual Residence of Decedent	6. Sex		e (In yrs. Ia	st birthday) Yrs.	If Under 1 Months		f Under 24 Hours	Hrs. 8 Min.	3. Date of Birtl (Month, Day 04/22/	h (, Year) 1939	Cou	hplace (State or Foreig untry) nsylvania	n
	/land f show ed at	tor	10a. State 10b. Coun	ty	, ,		, Town or Loc	ation							10d. Inside City Limits	s
	r 28a- notifie	Funeral Director	Maryland Balt:	umore			Essex	10f. Zip C	`odo				10. 0:::		1 🗆 Yes 2 🔀 N	ю
	with th	eral	339 Sassafras 1	Road				1	2122 [.]	1			10g. Citizen	of What Co	untry?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ M 3 ☒️Widowed 4 □ Divorce	arried 1 [s Decedent Ened Forces? Yes 2 🗓 es, Give		Н	Vas Deceder Yes, specify	/ Cuban, I	Mexican, P		fy Yes or No- can, etc.)		Race - Amer Black, White cify: Wh		
Maryland 21215-0036	thin 72 hours ene. than "natur he Medical I	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12	lent's Education hest grade comp		+)	(Give k	ient's Usual (kind of work of NOT use re	done duri	on ing most of	f working	J.	16b. Kind o	of Business/		
land 2	d 2 should be filed wi alth and Mental Hygis 127 is marked other er traumatic event, the	Be	17. Father's Name (First, Middle John Belford Ed	· · · · · · · · · · · · · · · · · · ·			DIII	/er	11		,	First, Middle, i .a May	Maiden Surn	ame)		
Nary	should and N is ma raumat		19a. Informant's Name/Relation		,							Route Number	-			
e, N	and 2 Health tem 27		Martha Joyce A. 20a. Method of Disposition	Lexandei	r (Daug		1) 319 lace of Dispos			Lane,	Win				3487 Town, State	
<u>m</u>	Page 1 nent of l ant: If it		1 🔀 Burîal 2 □ Crematio 4 □ Donation 5 □ Other		al from State	CE	emetery, crem ly Hil	natory or other	er place)	rd.09				-	Maryland	
Baltimore,	permit. Page Department of Important: If any injury or once.	<	21. Signature of Function Service	Licensee	>		22	. Name and a	Address o Bruz 1d Ea	of Facility Zdzin aster	ski n Av	Funera enue,	l Home Essex	e, P.A Mary	land 21221	
				or complications t only one cause	on each line		n. Do not ente	r the mode o	of dying, s	such as car	rdiac or r	espiratory arn	est,		Approximate Interval Between Onset and Death	
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	ate be executed bhysician and the burial-transi	I Exa	that initiated events resulting in death) Last	c. —	Due to (or as a	conseque	ence of);						-			
09,	ate be ohysici the bu	edica		d								···				_
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 L 4 L	es, outcome of Live Birth : Pregnant at Unknown	2 🗌 Fetal	Ideath 3 🗌	Ectopic pre Other (spec					23d.	Date of deli Month	ivery Day Year	
s, P.O.	res that th signed by d be detac	d by Ph	Part II. Other significant condi		_	ut not resu	ulting in the u	nderlying car	use given	in Part I.		23e. Did to	1		the cause of death?	/n
ord	w requ	Completed	Ac	moet doni					-			24a. Was a	an 24	4b. Were aut	opsy findings available	9
Rec	The la cate ha	Com	9									autop perfoi 1 Yes	med?	death?	completion of cause of	
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	icate: To	27. Manner of Death 1 Natural 5 Pend		1 ☐ Inpatie . Date of injur (Month, Day	у	ER/Outpatien 28b. Time of injury		injury at work?		28	e 5 🛣 Resid d. Describe h			<u>-</u>	
Division	ital or Atte ins after de al Directo	al Certificate:		mined 28e.	. Place of Inju building, etc	. (Specify)			_			City or Tow	n, State)		ral Route Number,	
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 ☐ Medica	ng Physician: To I Examiner: On t ng Nurse Practi	the basis of ex	amination	and/or invest	igation, in my	opinion,	death occur	irred at th	e time, date ai	nd place, and	due to the c	ause(s) and manner sta	ted.
	To the within comp		30. Name and address of persons of Date filed (Month, Day, Year) SEP 2 4										29d. Date siç		, Day, Year)	
			30. Name and address of perso	n who complete	d cause of de	eath (Item	23a) (Type, P	rint) Balor	nze	M		2120	りつ			
	Stat Registra	le ar	31. Date filed (Month, Day, Year)	2012	32 Registra	r's Signati	1. pa	New .						,		

DHMH 17 Rev 06-2011

		•	For State	Pleas	State of		d / Depa	rtment o		and M	lental Hy	giene	egible. 0 2	
1	Physicia	n/	Registrar 1. Decedent's Name		_ast)		Cer	meate	Dealii		2. Date of De	ath		3. Time of Death
-	Medic Examin	er	4a. Facility Name (if	not institution, g					n, or Location		SEPTEM	4c. Cou	unty of Death	
_	Funeral		5. Social Security Nu		HNGTON V	MBOUA '. Age (In yrs. Ia		If Under 1 Y	ear If Unde	y 150 er 24 Hrs.	8. Date of Bir		UNE 9 Birt	hplace (State or Foreign
	Director		181.30.5636 Usual Residence of	5	1 □ M 2 KX F	75		Months Da	ays Hours		(Month, Da	y, Year)		PA
	land I show dat	tor	10a. State	10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
	ie Mary ir 28a-1 notifie	Director	MD 10e. Street and Num	ANNE ARU	NDEL	SEVE	RN	10f. Zip Co	nlo.					1 🗆 Yes 2xx No
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بيا	death ritems iner m		11. Marital Status		12. Was Deced	es?			of Hispanic O Cuban, Mexica		cify Yes or No- Rican, etc.)		Race - Amer Black, White	
458	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ed by	1 ☐ Never Marri 3 ☐ Widowed		1 ☐ Yes If Yes, Give Year or Date		1	☐ Yes 2	No Specif	y:		Spe		
15-0	72 hou n "natu fedica	Completed			s Education grade completed)		(Give k		ne during mo	st of worki	ng	16b. Kind o	of Business/I	Industry
212	within giene.		Elementary/Seco	ndary (0-12)	College (1-4	l or 5+)		NOT use reti	,			ACCO	UNTING	
2001 aryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (F		t)					her's Name	e (First, Middle,	Maiden Surn	ame)	
(A) E	should be and Mer is marke raumatic		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailin	g Address (Str			I Route Numbe	er, City or Tow	n, State, Zip	Code)
, e	and 2 Health tem 27	ŀ	LINDA BOB 20a. Method of Disp		P	0A 20b P	7405 O				BURNIE,			Taura Chaha
Baltimore,	Page 1 nent of ant: If if ury or o		1 🗌 Burial 💥		Removal from S	State	emetery, crem RO CREMA	atory or other	place)	9.19.2	Date 2012		on - City or T	
E S	permit. Departr Imports any injt	l (2	21. Signature of Fur	eral Survive Lice	-	M011	22 F11 148 420	Name and Ac NK FUNER 5 CRAIN	tdress of Faci AL HOME, HWY SW C	P.A.	RNIE, MD			
			23a. Part 1. Enter the shock, or hear	ne disease, or co	omplications that ca y one cause on eac	used the deatl h line.								Approximate Interval Between
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	be executed sician and burial-transit	cal Exa	that initiated events resulting in death) L		C. Due to (o	r as a consequ	ience of):							
260	cate be physic s the br	edica			d									
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ïtal	sician: certific irector,	Be	25. Was case referre examiner? 1 Yes 2		Hospital:				6. Place of De		only one)			
of V	ng Physter this	te; To	27. Mann of Death		28a. Date of	npatient 2 finjury , <i>Day, Year)</i>	ER/Outpatient 28b. Time of injury	28c. I	4 □ N njury at work?		me 5 Resid			fy)
ion	ttendir death. stor: Af y the fu	Certificate;	1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigat 6 ☐ Could no	ion	f Injury - At ho		М	I ☐ Yes 2 ☐					
Division of Vital Records,	ital or A irs after al Direc led in by	al Cer	4 🏻 Homicide	determine		g, etc. <i>(Specify,</i>		et, lactory, off	ice		281. Location (S City or Tow	Street and Nu vn, State)	mber or Run	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2		hysician: To the beaminer: On the basis urse Practitioner:	of examination	and/or investi	gation, in my o	pinion, death of	occurred at	the time, date a	and place, and	due to the c	ause(s) and manner stated.
	To the with To the com		29b. Signature and t	itle of certifier	712		MD	29c. Lic	ense number	514	9	29d. Date sig	gned (Month,	, Day, Year) 18 2012
5			30 and addre	ss of person who	o completed cause	of death (Item	23a) (Typa, Pr	int) elv	Le .	Gle	u Bu	rnie	Mi	20161
	Stat Registra		31. Date filed (Month	2 4 201	2. Rec	gistrar's Sign t	ure				-			
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			■ State	epartment of Health and Certificate of Death	, ,	2012	30411
			Registrar 1. Decedent's Name (First, Middle, Last)	Sertificate of Death	2. Date of Death	g. No. Z U I Z	T-00:::
	Physicia Medic		Frank William Fogle		Month September	r 17 2012	3. Time of Death 9:35 P M
î	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
_	<i>i</i>		10121 Clemsonville Rd.	Union Bri	.dge	Fre	ederick
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth _(Month, Day_Y	9. Birth Cou	nplace (State or Foreign ntry)
п			220-30-9146 1 × M 2 F 95 Y	rs. Mortale Baye Michael Minn.	Jan. 27	, 1917 M	aryland
	and show	ö	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Maryl 18a-f tifiec	rec	Maryland Frederick	Union Bridge		i	1 ☐ Yes 2 🎛 No
	the I	<u>ۃ</u>	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	s 23; nust l	Funeral Director	10121 Clemsonville Rd.	21791		Ü	J.S.A.
	deatl ritem nern		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	
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pu	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Mai	iden Surname)	
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Ma	2 sho th and 27 is r		l =	Mailing Address (Street and Number or Ru			
e,	and Heal tem 2			121 Clemsonville Ro		n Bridge,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place) 11e Meth. Cem. 9/20	. [Oc. Location - City or T	
alti.	mit. Partmoortai	1	21. Sign / f Find al Service Licensee	22. Name and Address of Facility Ha		Johnsville	
m	an Ber		affarine V. Harler	11802 Liberty Rd.			21762
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate outco. Enter Underlying Cause (Disease or linjury				
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٥ ×	eath certificat attending ph	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of deliv	very
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Žį.	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death (Chec			
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on	eath. or: Af	fica	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O. Box 687	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the best of my knowled	estigation, in my opinion, death occurred a	at the time date and r	place and due to the ca	use/s) and manner stated
	Vithir Comp	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	(1		I Stankke und	D31058		9-19-1	
			30. Name and address of person who completed cause of death (Item 23a) (Tyl	pe, Print)			
			Gene Ashe 31. Date filed (Month, Day, Year) SEP 2 4 2012 32. Registrar's Signature	oppermine Rd.	Woodsbo	ro, MD 217	98
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	3,000		DEL S. A COLL MAN.				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER14 IRVIN FRIEDMAN 201 8:59A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. (Month, Day, Year) 212-60-8568 Director 1 X M 2 D F 58 05/26/1954 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No OWINGS MILLS MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3414 ASSOCIATED WAY 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 DRIVER TAXI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be FRIEDMAN NETTIE FINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 3414 ASSOCIATED WAY, OWINGS MILLS, MD 21117 STANLEY FRIEDMAN/BROTHER timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 09/19/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) BNAI ISRAEL CONG. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Balt SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death 5 M I N U T E S MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Examine Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b NON-INSULIN DEPENDENT DIABETES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy Hospital or Attending Physician: The 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 K ER/Outpatient 3 I DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident after death Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D60005 Name and address of person who completed cause of death (Item 23a) (Type, Print)
BENJAMIN VANLANDINGHAM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

SEP 2 4 2012

		State of Maryland / Department of Health and Me	ental Hyg	iene	
		1 - State Registrar Certificate of Death	R	eg. No. 201	2 30413
Physicia			Date of Death Month	Day Yea	3. Time of Death
Medic Examin			9	19 20	
	-	Baltimore Veterans Affair Med Cfr. Baltimore		4c. County of De	NIA
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign
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Many 28a-	Director	N.V. Kings Brooklyn			1 🖰 Yes 2 🗌 No
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1		I SU. Name and address of person who completed cause of death (Item 23a) (Type, Print)			21201
State	3	31. Date filed (Month, Day, Year) 32 Registrar's Signature	More	1 120	
Registrar		SEP 2 4 2012 Certain S. Jacks			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18, 2012 Gloria Ellen Glenn 0955 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death n/a Baltimore 2410 Arunah Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 06/14/1938 Maryland **Director** 220-38-6590 74 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD n/a Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 21229 41 South Culver Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceuent 2... Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: Black 3 ₩ Widowed 4 Divorced and Mental Hygiene.
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aumatic event, the Medical f 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook & Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill rtment of Health and Mental rtant: If item 27 is marked on nury or other traumatic ew ျှ Ella Kay William Gayle Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Arunah Avenue Baltimore, MD 21216 Tonya Wilson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place)
Cremation Ctr of MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donafon 5 ☐ Other (Specify) 9.24.2012 Hanover, MD lure Funera John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between k, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ TA STATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a someoquenes of: Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) pec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 performe 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 Xother (Scaughter's home 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After injury XNatural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deatle Funeral Director; completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29c, License number **D** 16354 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOO CATON AVE BALTIMORE MD, 21229 AGNES

X DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

eronica Gray		State of Maryland / Department of Health and Mer Certificate of Death	ntal Hy		20	12 3041
Physician	n/	Registrar 1. Decedent's Name (First, Middle,Last) Veronica Gray	1	2. Date of Deat	Day Year	3. Time of Death 0659 hrs
ledical Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	n of Death	Septembe	4c. County of De	eath
		University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year If Under 1 Year	dos O.Aldeo	Dots of Die		N/A Birthplace (State or
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eath with the Maryland items 23a or 28a-f sho ust be notified at once	Director	10e. Street and Number 1201 Winchester St. 21217		10	og. Citizen of What C USA	Country?
2 2 E	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Press (by Paer of Dates) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Yes 2 No 11 Yes 2 No specify	an, Puerto R y:	Rican, etc.)	Mhite, etc Afric Specify: Am	an er.
J036 within 72 hours ene. er than "natur Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) Manager	T use retire	ed)	16b. Kind of Busine Food	ss/Industry
MD 21215-0036 12 should be filed within 7 12 is and Mental Hygiene. 12 is marked other than unatte event, the Medies	8	Lewis Coleman Rut	h R.	Reyno		
MD 2 d 2 should lth and M in 27 is m numatic c] ≏	19a. Informant's Name/Relationship (Type, Print) Nikcole Gray/Daughter 19b. Mailing Address (Street and Number 102 Villiage 30 Williage			ber, City or Town, S , Windsor	tate, Zip Code 21244 Mills,MD
Baltimore, oemit. Pages landepartment of Heal Important: If iten injury or other tra	I	20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory	9/2	Date 29/12	Balt., M	Or Town, State
Balti permit. Departn Imports	Į	21. Signature of Puneral Scribe Licens 22. Name and Address of Facility 5126 Belair	Hari Rd,E	P. C.	lose F.S MD 21206	vs PA -5105
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated				
cuted ind transit	EX	events resulting in death) Last Due to (or as a consequence of): d.				
be exe	edical	UNPENDED AMENDED				
Box 6876 death certifica te attending ph d for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopi	oic pregnan	cy	23d. Date of deli	very Day Year
P.C es that igned be deta	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.		bacco use contribute 2 No 3 F	to the cause of death? Probably 4 Unknown
Records The law requicate has been	Completed			24a. Was a autops perform	sy prior med? death	
Vital ysicians his certi	g R	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other 4	h (Check or Nursing		Residence 6 O	ther:
ट # 3 [₹] #	IIOII:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Natural 5 Pending Sep 16, 2012 28b. Time of Injury 28c. Injury at World 1 1 Yes 2 ✓	_ lp		ow injury occurred struck by auto	
Division Hospital or Attendi 24 hours after death. Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		or Town, St		Rural Route Number, City
	Medical	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.				
To with To Com	Ē	29b. Signature and title of certifier 29c. License number O.C.M.E.	er		29d. Date signed (
		30. Name and address of person who completed cause of death (Item 23a)				
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	t, Baltimo	ore, MD 212	223	
Star Registra		SFP 2.4 2012				

9	EP	_/-	CEMENT	Type or Print in Black State of Maryland / D	k Indelible In epartment of I	k. Ensure Health and	All Copie Mental Hv	s Are Le ç aiene	jible.
		10	State Registrar 1. Decedent's Name (First, Middle, La.	(Certificate of	Death		Reg. No. 2	112-30416
	Physicia Medic		Gladys Jean	Hallyburton				/31/12	Year 3. Time of Death 5:32pm M
may refer	Examir	er	4a. Facility Name (if not institution, give Baltimore Washin	e street and number) ngton Medical Cent	er Glen I	or Location of Deatl B urnie	1	4c. County Anne	of Death Arundel
	Funeral Director		5. Social Security Number 386–24–3722 Usual Residence of Decedent	Fiex 7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 7/10	ıy, Year)	Birthplace (State or Foreign Country) MO
	Maryland 28a-f show	rector	10a. State 10b. County	ne Arundel 10c. City, Town of	en Burnie				10d. Inside City Limits 1 □ Yes ※X No
	s 23a or 2 s ust be no	Funeral Director	10e. Street and Number 7975 Crain High	nway # 120	10f. Zip Code	21061		10g. Citizen of	What Country? USA
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎛 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1f Yes, Give Year or Dates. Army	13. Was Decedent of HI If Yes, specify Cub.		pecify Yes or No- o Rican, etc.)	14. Rac Bla Specify	e - American Indian, ck, White, etc. : White
21215-0036	n 72 hou e. ian "nati Medica	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) ((Decedent's Usual Occup Give kind of work done fe. DO NOT use retired,	during most of wor	king		usiness/Industry
d 21	ed withi Hygiene other the	Be Cc	12 17. Father's Name (First, Middle, Last)	0	Home Care			Maiden Surnam	lth Care
Maryland	ild be fill Mental narked o	욘	Clarence A. (Glover		Hett			,
	nd 2 shou ealth and m 27 is m	ı	Jeffrey Hallybu		Mailing Address (Street 9 Cedar Dri				
Baltimore,	Page 1 arment of He cant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ∑ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State OakView	Disposition (Name of crematory or other plane) Cemetery	^{ce)} 9/1	Date 0/2012	20c. Location Royal	- City or Town, State Oak, MI
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Licens	Victor P. Doda	22. Name and Addre	ess of Facility 7an & Son	705 W. Royal	. 11 Mil Oak, M	e Road I 48067
إشمر	Physician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Hip Fracture Con	mplicating	Hyperten	or respiratory ar		Approximate Interval Between Onset and Death
	Examiner	ř	Sequentially list conditions,	Due to (or as a consequence of)	3.188	scular Di	sease	1 11)
	executed sian and urial-transit	Examiner	if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.		D. well	Thuthe	EDICAL EXAMINER	
09289	ate be exec physician ar the burial-1		resulting in death) Last	Due to (or as a consequence of) d	:	O CERTIFICATION	APPROVEDO		
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be elements after death certificate be elemental piecetor. After this certificate has been signed by the attending physicial tely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnant 5 Other (specify)	су			ite of delivery onth Day Year
s, P.O.	requires that the been signed the should be det	ठ	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause gi	ven in Part I.			ribute to the cause of death? 3 Probably 4 Unknown
of Vital Records,	The law requate has beer page 2 shou	Completed					24a, Was autor perfo	osy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ital	sician: The lar certificate har lirector, page 2	Be	25. Was case referred to medical examiner? 14 Yes 2 □ No	Hospital:	Oth	lace of Death (Che	ck only one)		
of V	ding Physician: 1 th. After this certifice funeral director, p	ate: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1XXnpatient 2 ☐ ER/Outp 28a. Date of injury (Month, Day, Year) 28b. Tin	ne of 28c. Injury work	4 □ Nursing F y at	28d. Describe h	dence 6 Oth now injury occurr FeII W	
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completely filled in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm		Yes 2 🔀 No	Out 28f. Location (S	of Bed Street and Numb	er or Rural Route Number,
Ο̈́	pital or ours afte eral Din filled in	cal Ce		building, etc. (Specify) Assisted Living sician: To the best of my knowledge, de		e date and place	1		e, Pasadena MD
	the Hos nin 24 ho the Fun npletely	Medical	(Check 2 Medical Examonly one) 3 Certifying Min	iner: On the best of my knowledge, de iner: On the basis of examination and/or in se Practitioner: To the best of my knowle	nvestigation, in my opini edge, death occurred at	on, death occurred the time, date and p	at the time, date a	and place, and du	e to the cause(s) and manner stated.
	with Concept		29b. Signature and title of certifier	_	29c. Licens D007	e number 73546		29d. Date signe 9/17	d (Month, Day, Year) /2012
•			30. Name and address of person who a Justin Papk, MD	completed cause of death (Item 23a) (Ty 1600 Crain Highwa	pe, Print) ay, Suite 4	.01 Glen 1	Burnie M	ID 21061	
	Sta Registra		31. Date filed (Montil, they, Year)	32. Registrar's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Voor LOIZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Scours Baltemore Bultimore Mary land 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Director 230-30-6761 1 □ M 2 🗓 F 83 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director must be notified Baltimore NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 21217 **USA** 1446 N. Mount Street 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. African ò 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 ☐ Divorced Specify: American "natural", Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Restaurant id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Golden Dragon 8th Grade Cook NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Harris Collins Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health a tant: If item 27 is 1446 N. Mount Street Baltimore, Maryland 21217 Vondella Harrison-Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Park 20c. Location - City or Town, State injury or 1XXBurial 2 Cremation 3 Removal from State Important: If any injury or 09-28-12 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months' 1 Yes 2 No Day Pregnant at time of death Other (specify) 9 Unknown 9 Ulnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy prior to completion of cause of death?

1 Yes 2 No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Accident Investigation 24 hours a er deat Funeral Director filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifie

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

73537

WIVASAN BonSecours Hospital 2000 W. Baltimore Street

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#20a-cperff, 6931, 9/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 Delois Jean 11:30 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WEST ArliNGTON NURSING CTR BAUTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-31-19 40 **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Months Days Min 2 Yrs. Director 238-62-7576 NC Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 X Yes 2 🗆 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ENH URST HVENUE USA 21215 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify. "natural", Specify: Black 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) DEPT OF DEFENSE 4DMINISTRATIVE ASST 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eddie Moore Margaret ANDREWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) · BALTO, MD . 21209 3010 HAIRSTON MANOR CT VANESSA Daughter 20a. Method of Disposition UNK Date UNK 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 10/1/2012 **Arbutus Cemetery** 22. Name and Address of Facility VANGHN GLEENE FUNCTIONS 21. Signature I Funeral Service Livensee RIAO. BATIMOre, MO. 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Dehrdrahie days disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Denen YEAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Pranhusia within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 2 🗌 No 1 Yes **Division of Vital** Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis or examination and/or investigation, in tity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatura 29d. Date signed (Month, Day, Year) 043786 9-19:12 2120 i 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 44 to ward 410 N Naca 31. Date filed (Month, Day, Year) State SEP 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2012 Jose Rau1 Ruiz Hernandez 22;51 Sept. 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Randallstown Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 433-87-1793 Director 1 XM 2 □ F 11-13-1925 Rep. Of Honduras 86 items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Jefferson LA Gretna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Republic Of Honduras 70056 East Lexington 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian Black, White, etc 2 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed Honduran White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Acrobat Circus Maya Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Hernandez Amalia Jose Maria Ruiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 912 East Lexington Ave. Gretna, LA Juana Mora 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 9-21-2012 All Saints Cemetery | Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat ervice Licensee 22. Name and Address of Facility ELINE FUNERAL HOME Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate lure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final SCV Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signa page 2 should be 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ※ No 24a. Was an autopsy certificate 2 X No Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No Hospital: မ 1 Yes 1 Inpatient 2 XER/Outpatient 3 IDOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1-X Natural 5 Pending Accident Investigation after death Director: / filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical within 24 hound To the Funer completely file 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062650 September 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 ald court road randalls town MD 21133 (naibi

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 24

32. Registrar's Signature

			For		State of	Marylar		artment of I		and M	1ental Hy	giene		0	20121	7
		Treg. Hor has to a new trees.											30420	<u>ر</u>		
	Physicia Medic		Nora	_		2. Date of De Month Septe:		nber 19, Year 1:35 p M								
my	Examir		4a. Facility Name (if not insti-	e street and numbe		4b. City, Town, o	r Location o	of Death		4c. County of Death						
-			Futurecare 5. Social Security Number	to a de trade atoria.	Reis	If Under:		0.0		Balt:			_			
	Funeral Director		215-12-5235	6. 5	1 M 2X F	Age (In yrs. i	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	C	ountry		
	_ MC		Usual Residence of Deced	ent							July 2	3, 1	916 No	rth	Carolina	_
	ryland -f sho led at	ctol	10a. State 10b. Co	,		10c. Cit	ty, Town or Lo							100	I. Inside City Limits	
	or 28a notif	Director	MD 10e. Street and Number	ватт	imore			Reiste	erstov	V11		10a Cit	1 ☐ Yes 2 🛣 No			
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ary	2 should be th and Men 27 is marke traumatic		19a. Informant's Name/Rela				19b. Mailir	ng Address (Street					Town, State, 2	in Cod	de)	
			Susan J. Cou	ırtne	y Daug	hter		indellen							136	
ore,	nit. Page 1 and 2 partment of Healt oortant: If item 2 injury or other ie.		20a. Method of Disposition 1	ation 2		20b. F	Place of Dispo	sition (Name of natory or other place	ce)	С	Date	20c. Lo	ocation - City o	r Towi	n, State	_
Baltimore,			4 Donation 5 Ot			ato	•	emetery		9/22	2/12	Cra	igtown	, M	aryland	
Ball	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Ser	vice Licen	m ge	nke		. Name and Addre			1824 Re Reiste		rstown wn, MD		ad 1136	
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-	h sician/		Immediate Cause (Final disease or condition	7000	- Athr	we sch	evertic	cerebral	Vasz	u/a	- dise	يا جي			nset and Death	
1	Medical Examiner	П	resulting in death)	ſ	Due to (or	as a consequ	uence of):							7		
	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death careful that the function of the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ner	Sequentially list conditions, if any leading to in neclationause. Enter Underlying	as a numero	uente dij:							\vdash		_		
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260	cate b physi s the t	edical			d									<u> </u>		_
89	certifi inding use a	M/u	IF FEMALE: 23c. If yes, outcome of pregnance					ancy al death 3 □ Ectopic pregnancy						23d. Date of delivery		
Box 687	res that the death certific signed by the attending f d be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		4 Pregna 9 Unknov	nt at time of	death 5	Other (specify)	topic pregnancy her (specify)					Month Day Year		
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12-07068
Angela D. Horton

Physician

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State of Maryland / Department of Health and Mental Hygiene

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4 Homicide determined (Specify) Single Family Home 1835 Montreal Road, Severn, MD 29a. Certifier 1 Certifyling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ViSi or Att fter de Direct in by	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.		or Rural Route Number, City						
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September 20, 2012	1-01		Carde Hallai	O.C.M.E.	September 2	0, 2012						
30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	19/W			Raltimore Street Raltimor	e MD 21223							
Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature	1/4	tate		Daitinois Ottest, Daitinioi	O, MD 2 1220							

DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O'COT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Hours (Month, Day, Year) Director 466-18-8492 1 XM 2 □ F 96 Usual Residence of Decedent May 11, Texas r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 Gill Street 21113 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1934 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 2 No 1969 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4 or 5+) Command Sergeant Major United States Army Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Jefferson Hickey Rosalie Wector 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen Cooper / Son-in-law 1304 Gill Street Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Nichols-Bethel 1 X Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Cemeterv 21. Signa of uneral Service Licens 22 Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Operand Death ENEBRO Physician disease or condition resulting in death) Medical Due to (or as a consequence of) [']Examiner Sequentially list conditions. Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4. Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 | Yes 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? MANDRIN 6 D Other (Specify) ဂ္ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Signature and title of 29d Date signed (Month, Day, Year) 72012 Name and address of person who completed cause of death (Item 23a) (Type, I 31. Date filed (Month, 2 4 2012 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 20,2012 6:05 AM 4a. Facility Name (If not institution, give street and number) V bbard September /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 8, 1926 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F 85 Maryland Director 214 22 2573 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 🙀 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō items 23a 1937 Silver Lane 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No ò Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Production Worker Can Mfq. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward H. Becker Edith Margaret Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Cascio (Daughter) 1937 Silver Lane Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery 9/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature) of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Han W Burkouske Bruzdzinski Funeral Home P.7 1407 Old Eastern Avenue Esse 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Burkous 23a. at 1. Enter the disease, or complications that caused in ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or user, ing Cause (Disease or injury Examine Due to (or as a consequence of) physician and that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DCA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending 1 🔲 Yes 2 No death. investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide the Hospital e Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 20,2012 D0068924 110 person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed State

Registrar DHMH 17 Rev 1/2001

11595

Box 68760.

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 1<u>9</u> Physician/ Month Ray Hutton, Sr. September 2012 3:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospice Dove House Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours **Director** 216-38-4357 1 🛛 M 2 🗆 F 70 Dec. 28, 1941 Virginia Usual Residence of Decedent or than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Westminster Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21158 U.S.A. 3502 Old Hanover Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) t of Health end Mental Hyglene. If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) construction 10 carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Shirley Morris Raymond Ray Hutton other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Old Hanover Rd. Pege 1 and 2 Margaret M. Hutton/ wife Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 Depertment of Importent: If It any Injury or o 1 D Burial 2 🔀 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 9/21/2012 Sykesville, MD Signa yr Juneral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home, athanine 310 Church St. New Windsor, MD 21776 Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physicien end I for use es the burial-trensit or Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pege 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completely filled in by the funerel director, peg 1 ☐ Yes 2 ☐ ₩6 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2. L. NO မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manus of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 Accident 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dittle of certifier Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter 555 S Center St Westminster, MD 21157 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Ralph Edward Henderson 4: U3 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Battimore 10x2 osedale **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 239-22-2445 **Director** 1**X** M 2 □ F 93 04/19/1919 North Carolina Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Wilson Point Road, Apt. E 21220 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? 1 Never Married 2 Married þ 1 XYes 2 □ No If Yes, Give Year or Dates. and Mental Hygiene. is marked other than "natural", 1 Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced WWII Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tool Maker 12 Aero-Spa**c**e permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Columbus Henderson Nora Rockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Mizelle (Daughter) 1652 Manor Road, Dundalk, Maryland 21222 aftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State emetery, crematory or other place) Holly Hill Mem. Gard. 09/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) atrito of Principal 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 🗌 No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Fallure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No မ 1 Yes Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier DOOG HEGT pleted cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

		A	MEND #25,	Plea PER ME	se Type or G931_9/2	Print in	Black In	ndelible In	k. Ensure	All Copie	es Are Le	gible.				
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	oermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director		OUNG	PLACE	5		10f. Zip Code 217	01		10g. Citizen of		ntry?			
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			23a. Part 1. Enter shock, or hear	t failure. List or	ly one cause on ear	ch line.	. 0			ac or respiratory a	rrest,		Approximate Interval Between Onset and Death			
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Division	Il or Attendi after death. Director: Ai d in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no	ot be 28e. Place				Yes 2 No	28f. Location (Street and Numb	ber or Rural	Route Number.			
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7	To the with Com.		29b. Signature and t		na	MD		29c. Licens		П	29d. Date signe					
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only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(see 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date 20b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date 20b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date 20b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 20c. License number 20c. License nu									ate signed	d (Month	, Day, Year)	2012								
				30. Name and addre	ess of person of	who com	apleted cause of	4	223a) (Typ	pe, Print)					BALT	IM	ORE	= _	212	2-9
		Stat Registra		31. Date filed (Monti	h, Day, Year) P 2 4 2	012	72. Reg	istrar's Signa	ture	arke	,									

andre Michael Jo		1- For State	tate of Maryla		partment of ertificate of		d Ment	tal Hyg		Reg. No.	20	12	3042
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	lle,Last)						Date of Dea	ath	Year		Time of Death
Medical Examir	ier		Michael	Johnso		th City Town or	Location		Month Septemb				1422 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1005 N. Woodyear Street Baltimore								c. County of Death NA			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Yea			8. Date of B	irth(MM/D		Birthpla	ace (State or
Director		213-76-8147	1XM 2F	53	Yrs	Months Day	s Hours	Min.	11-20	- 58	Fo	reign Countr	y) MD
>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								140	d. Inside City Limits			
iow any			ÍΑ		altimore	OII				1 X Yes 2			
aryland	Director	10e. Street and Number		De	ITCINOLG	10f. Zip Code			1	10g. Citize	en of What C		
ith the Maryland 23a or 28a-f sho notified at once.		1005 N. Woody	ear Street			212		USA					
hours after death with the Maryland bratural? or items 23a or 28a-f she Examiner must be notified at once	uneral	11. Marital Status	12. Was Dec			s Decedent of His							
er deat	티	1 Never Married 2 N 3 Widowed 4 Dir		If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 ^{XX} No specify:					Specify: Ar				
urs afte	칅	15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grad			's Usual Occupa		and of wor	k done		nd of Busine		
2 2 = =	흉	Elementary/Secondary (0-12)	College (1			ost of working life	DO NOT	use retired	i)	var	ious 1	trac	les
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	7th Grade (NA									- Luc	
	8 8	17. Father's Name (First, Middle John Ric		Pettus			18.Mother:		irst, Middle, Sv	Maiden S /lvia		ohns	son
2121 2121 Duld be fi Mental marked ic event,		19a. Informant's Name/Relations			19b. Mailing	Address (Stree						tate, Zip	Code)
mand 2 shou sealth and N tem 27 is n traumatic	1	Dora Bates-Au	int						_				MD 21223
Baltimore, MI permit. Pages I and 2 s Department of Health as Important: If item 27	- 1	20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fro	m State	. Place of Dispos crematory or oth	er place)			Date		cation - City		n, State
Baltimore, cernit. Pages I a Department of He Important: If ite	ļ	4 Donation 5 Other S			Trinity	-			4-12		dalk,		-
Bal permit Depar Impo		21. Signature of Funeral Service	1 nsee		122. N	ame and Address	mor S	Wy Stree	lie Fi t Balt	mera imor	I Home e. Mai	e P. cvla	A. and 21217
Physician		25a. Part. Enter the disease, or		used the deat								A	pproximate Interval
/Medical Examiner	ı	failure. List only one cause Immediate Cause (Final disease	34 - 1 - 1	e Into	xication	1						_ '	Between Onset and Death
- Examinor	-	or condition resulting in death)	Due to (or as a	consequence	of):								
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):							+	*****
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	2002000000	of):							-	
uted uted id ransit		events resulting in death) Last	d.	consequence	Gi).								
be executed ician and urial - transit	dical -	X UNPENDED	AMENDED 2	3a,27,	28a-f,pe	r me,g9	31 9-2	28-12	sm				
Box 68760, e death certificate by the attending physic of for use as the but	\$	IF FEMALE: 23b. Was decedent pregnant in t		utcome of pre							Date of deliv	-	
K 68	Cian	past 12 months?	I I TIME D	rtn ant at time of c	tooth -	aldeath 3 ner <i>(Specify)</i>	Ectopic	pregnanc	у	Month Day Year			
BO)	Physician/Me		known 9 Unkno										
P.O. es that the gened by e detach		Part il. Other significent condi	tions contributing to	death but not	resulting in the u	nderlying cause (given in Par	t I.		_	_		cause of death?
ords, F w requires t us been sign should be	Completed by								24a. Was				y findings available
COL law re has be	톍									ormed?	prior death	to comp	letion of cause of
tal Recinitate Certificate		25. Was case referred to medica	al .			26 Place	of Death (Check onl		2No	1 🗸	Yes	2 No
Vita hysician this cer	10 Be	examiner? 1 ✓ Yes 2 No	Hospital: FT	patient 2	ER/Outpatient				lome 5	Residence	e 6 🗸 OI	her: Sc	ene
ing Ph		27. Manner of Death	28a. Date ((Month,	of Injury Day,Year)	28b. Time of Ir		ry at Work?		d. Describe		occurred		
Sion treodi death. ctor:	(Natural 5 Pen 2 Accident Inve	stigation Id 9-	18-12	fd 2:08	Pm	Yes 2 X	- 100	nknown				
Division of Vital Records, pspital or Atteoding Physician: The law requiry hours after death. Incri Director: After this certificate has been signified in by the funeral director, page 2 should by	Certification:	dete	ld not be rmined (Specify)		home, farm, stree		ouilding, etc		or Town,	State) 1 () (05 N. V	Rural F	oute Number, City
hour hour hour y fill		4 Homicide 29a. Certifier	hysician: To the best	of my knowle	dge, death occur	ed at the time, da	ate and plac		Baltim e to the cau			tated.	
Division of Vital Rec To the Hospital or Atteoding Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical	(Official Office	miner:On the basis o	f examination									use(s)
FSFS	Ĭ	29b Signature and title of certific				29c. Licens				l l	ite signed (**
		Totalle	- toll	,		O.C.I	M.E.			Septe	ember 19	, 2012	<u> </u>
lend l		 Name and address of persor Patricia Aronica-Polla 				900 W. Baltir	nore Stre	eet. Bal	timore. M	D 2122	3		
Sta	ite	31. Date filed (Month, Day, Year)	32. Fe	gistrar's Signa				,	-, /				
Registr	ar	SEP 2	4 2012 /	ww	p. pa	Ked							

			Please Type or amen State o State amend item 8 per fh Registrar	Print in Blace	ck Indelible In	k. Ensure	All Copies	s Are Leg	ible.		
		-	State amend item 8 per fh	g932 10–26	Certificate of I	Death	vioritai i iy	Reg. No. 2	112 301.20		
I	Physicia Medic		1 Recedent's Name (First, Middle, Last)	(Jones		2. Date of Death Month Day 17 2912 15 33 PM				
	Examin	er	4a. Facility Name (if not institution, give street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the street and numing the	s Hospita	1 Dat	r Location of Death	My	4c. County N/A			
	Funeral Director		5. Social Security Number 212-26-8368 Usual Residence of Decedent	7. Age (In yrs. last birt) 83	Mantha Dave	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6 / 29 /	1929 2012	9. Birthplace (State or Foreign Country) NC		
	aryland a-f show fied at	ector	10a. State 10b. County MD N/A	10c. City, Town		11			10d. Inside City Limits 1 ✓ Yes 2 No		
	with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 263 N. Bethel Ct.	Daici	10f. Zip Code 2123	1		10g. Citizen of V			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decer	2 No	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 1 No		ecify Yes or No- Rican, etc.)	Blac	e - American Indian, k, White, etc. Black		
21215-0036	nin 72 hour ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4 or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired)	during most of worl	ding	16b. Kind of Bu			
and 21	uld be filed witt Mental Hygier tarked other t latic event, th	To Be C	4th N/A 17. Father's Name (First, Middle, Last) Needham W. Jones		Stock Cler	k 18. Mother's Nam Mable			ood Corp Marke		
Maryland	d 2 should talth and Me 27 Is mark r traumation		19a. Informant's Name/Relationship (Type, Print) Needham Jones-Brother		o. Mailing Address (Street	and Number or Rur	al Route Numbe				
Baltimore,	Page 1 and nent of Hes ant: If item ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☑ Ponation 5 ☐ Other (Specify)	20b. Place of cemeter	of Disposition (Name of ary, crematory or other place Hill Cem	ce) 25	Date	20c. Location -	City or Town, State		
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	es Am	22. Name and Addre	ss of Facility	March I	F/H-Eas	st e, MD 21202		
	Physician/		23. Part 1. Enter the disease, or complications that complete shock, or heart failure. List only one cause on each time tate Cause (Final disease or condition	h line.	not enter the mode of dyin	0 1	or respiratory arr	rest,	Approximate Interval Between Onset and Death		
)	Medical Examiner	r	resulting in death) Due to (c	r as a consequence o	of):	1-12-71011					
	e executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	r as a consequence of							
09289	physician the buria		d.	a de de de de de de de de de de de de de							
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 24 hours after death. After this certificate has been signed by the attending physici trely filled in by the funeral director, page 2 should be detached for use as the but the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properti	Physician/Medical	in the past 12 months?	ant at time of death	n 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	23d. Dat Moi	e of delivery nth Day Year				
ds, P.O.	requires that the dea been signed by the a should be detached t	ed by P	Part II. Other significant conditions contributing to de	ath but not resulting i	in the underlying cause gi	ven in Part I.			ibute to the cause of death?		
Vital Records,	vysician: The law red is certificate has be offector, page 2 sho	Completed by	2				24a. Was autop perfo 1 Yes	osv p	Vere autopsy findings available virior to completion of cause of leath? ☐ Yes 2 ☐ No		
lital	sician: The certificate irector, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 \(\subseteq \) No Hospital:		Oth	ace of Death (Chec	k only one)				
n of ∖	iding Phy th. After this funeral	cate: To	27. Manner of Death 28a. Date of		Time of 28c. Injury work	4 ∐ Nursing He yat		dence 6 Othe			
Division	al or Attendi s after death I Director: A id in by the f	Certificate:	3 Suicide 6 Could not be 28e. Place of	of Injury - At home, fai g, etc. (Specify)	rm, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best only one) 3 Certifying Nurse Practitioner:	of examination and/o	or investigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due	to the cause(s) and manner stated		
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			30. Name and address of person who completed cause DAVID MATS	of death (Item 23a) (Type, Print)	rleans	Stree	t. Bal	HADVE MD 21287		
/	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 4 2012	gistrar's Signature	bares	1 2					

DINNIT IT NEV 00-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 2012 Tommie L. Jenkins, Sr. PM 5:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5431 Todd Ave. Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) Director 421-36-8496 1 M 2 🗆 F 83 6/6/1929 AL Page 1 and 2 should be filed within 72 hours effer death with the Maryland ment of Health and Mentel Hyglene. Fent: If item 27 is marked other then "neturel", or Items 23e or 28e-f shoury or other treumetic event, the Medical Examplest must be mutified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5431 Todd Ave. 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3
Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Pastor Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Jenkins Hester Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romaine Jenkins-Wife Todd Baltimore Ave. MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemeter 9/24/2012 Baltimore. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East North Ave. 1101 Ε. Baltimore, 21202 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death pneumonia Physician/ disease or condition Medical resulting in death) Examiner Obstructive pulmonar BERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlei-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBVIllanun 1 Yes 2 No 3 Probably 4 Unknown cardio myopaitu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) willy on September 18, 2012 35102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HILLY DON M.D. 5901 NOVIN Baltimore Maryland 5901 North CHAYles Stret 31. Date filed (Month, Day, Year) Registrar's Signat State SEP 2 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 18, 2012 September 12:30 P M Chester Wilmore Johnson, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 1349 Yorktown Road 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours Director 1 € M 2 □ F 214-80-6540 53 September 6, 1959 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10d. Inside City Limits 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No <u>Annapolis</u> Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21409 United States 1349 Yorktown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🙀 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 Black 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Tractor Trailer Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 end 2 should be filed of Health and Mental H 2 Chester Wilmore Johnson, Sr. Bernice Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1349 Yorktown Road, Annapolis, Maryland 21409 Sandra Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 21 permit. Pege 1 e Department of H Important: If ite any injury or oth 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State cemetery, crematory or other powers that Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland ²² Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road. Odenton, Maryland 21113 Signature of Funeral Solvice Licenses MO1386 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complicate shock, or heart failure. List only one car Approximate Interval Between Onset and Death Immediate Cause (Final Hypertension Physician/ disease or condition resulting in death) Medical Due to (consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) Pregnant at time of death 1 ∐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of De ath (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D14136 20 112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALJIT 5. SAW HNEY Gien Burnie Towers 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30432 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 3:20 P Harriett Knight Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1840 Reisterstown Road Baltimore Pikesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) 229-48-0566 Hours Min. Director MS 1 🗆 M 2 🖾 F 80 Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pikesville 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21208 1840 Reisterstown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. African þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: American Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 k t of Health and Mental Hygiene. If Item 27 Is marked other than "n or other traumatic event, <u>the Med</u> Kernan Rehabilitation Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Nurse <u>Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jackson Irene Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 Windsor Avenue Baltimore, Maryland 21216 Jennifer Faulkner-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If II eny injury or or ō 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-01-12 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only give ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENTE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause Entar Undarying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?

1 Yes 2 No Day Year signed by the at id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALZHEZMET Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Other:
4 □ Nursing Home 5 □ Residence 6 🖾 Other (Specify) 1 ☐ Yes 2 PNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA LIVING 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30408 dress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

700 WOSHINGTON

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angela Langley Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death altimore 9. Birthplace (State or Foreign Maryn) and **Funeral** Social Security Number yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 F 0.60/108/108/10960 216-78-7232 52 Hours Yrs Director Usual Residence of Decedent 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 28a-f N/A Baltimore 1 X Yes 2 □ No MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 21217 23a Funeral 1707 N. Calhoun St. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 Completed by 1 Never Married 2 X Married within 72 hours after 1 ☐ Yes 2 ☑ No Specify. Black "natural", Specify: 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A12th Grade Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file
Department of Health and Mental I
Important: If item 27 is marked o
any injury or other traumatic eve Curry ည James Wiggins Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yardley Ct., Windsor Mill, MD 21244 Tanesha Williams(daughter) 21 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State King Mem. Park 09/22/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funds I Service Licensee අට්ර්ප්චේන්න් ජීව්ෂ්හ Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 L. Fetai uea Pregnant at time of death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day Month Year , the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💯 nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 1 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniun Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mosses M.

State Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical -ee OR . 54 PM 201 Facility Name (if not institution, give street and number) **Examiner** 4c, County of Death If Under 24 Hrs. Hours Min. **Funeral** last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 1 M 2 MD 28a-f shov items 23a or 28a-f shoner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner 9 þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than " ondary (0-12) College (1-4 or 5+) Provider and Mental Hygie is marked other other traumatic event, Be Middle, Maiden Surname) 18. Mother's Name (First, er or Rural Route Number, City or Town, State, Zip Code) it of Health a If item 27 i balto mo 21215 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Loçation - City or Town, State Date Department of Important: If it any Injury or o once. Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Liu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Ph, sician/ wei Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months.

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate to completely filled in by the funeral director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 700 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: Tothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) SEP 2 4 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER ME \$931 9/20/12 TRT Department of Health and Mental Hygiene For State Registrar 30435 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **8** Day 10 Physician/ 1830 Medical 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death 4c. County of Death MANY LANGMERICO BALTIMORE If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Days 61 Director 212-54-5560 1 🕮 M 2 🗆 F WASHINGTON, DC JUNE 1 1951 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 X Yes 2 □ No LANHAM MD PRINCE GEORGE'S ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20706 USA 9346 WORRELL AVENUE death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc.
BLACK ō þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify "natural" 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the TIRE TECHNICIAN PRIVATE 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ပ HELEN **BROOKS** GEORGE MARSHALL Page 1 and 2 should be nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc 9346 WORRELL AVENUE LANHAM, MARYLAND 20706 19b. Mailing Address (Street and Number or Rural Route Number, Important: If item 27 is any injury or other trau once. FLORENCE MARSHALL/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 8/17/2012 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Daphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** KEBRAL 12 H/2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami EXAMINER burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical CERTIFICAT requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ be detached for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law page 2 autopsy perform death? 2 No Yes the funeral director, 25. Was case referred to medical Be of Vital 26. Place of Death (Check only one) examiner? Hospital Other: XInpatient 2 □ ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 🔀 Natural Division 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Certifying only o e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d Date signed (Month, Day, Year) Aug II 2012 29b. Signat AL 06 1000 monglered gause of death (Item 20a) (Type, Print)

MARY WARD WARD WARD WARD WARD WE CARR, NE UZO LAKE IW 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20_ Physician/ Month MICHAEL MITCHELL 09 12:30 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A University of Manyland Medical Center BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 212-80-8338 Hours **Director** 1**У** М 2 □ F 10/07/1959 52 Maryland 28a-f show 10a State 10b. County 10c. City, Town or Location death with the Maryland 10d, Inside City Limits Director must be notified N/A Baltimore 1X Yes 2 No 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 1343 N. Woodyear St. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. à 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: natural Completed 3 Divorced Black marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Waverly Terrace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Claude Lee Mitchell Hortense Bailey 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 item 27 Harriet Eady-Mitchell 1343 N. Woodyear St., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ţ, 1 Byrrial, 2 X Cremation 3 Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any injury or once. on-site Crematory 09/38/13 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 3dsepHdHsBrown Jr. Funeral Home PA 2,40 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. End stage liver disease
Due to (or as a prosequence of): Medical Examiner rneumonia Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical been signed by the attending p should be detached for use as yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅌ 1 ☐ Yes 2 🗷 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide

Box 68760 P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

STEPHEN 12 SOUTH GREENE ST BALTIMORE, MD 21201 MIHALCIK 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1598031205

29c. License number

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

September 20, 2012

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Desedent's Name (First, Middle Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9678 Halstead Avenue Laurel Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 215-66-6412 1 ፟M 2 □ F Yrs. 56 Nov. 4, 1955 Massachusetts er than "natural", or Items 23e or 28e-f ahow the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9678 Halstead Avenue 20723 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XXIo Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiana. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) years Director of Sub Contracts Contract Negotiations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba file h end Mantal F 7 is marked or မ John Edward Marselle, Jr. Mary Ann Prusser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Page 1 and 2 sh Dapertmant of Haeith er Important: if Item 27 is any Injury or other trau once. Theresa Ellen Marselle / spouse 9678 Halstead Avenue Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 9/24/2012 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home. P.A. ∠ M00770 313 Talbott Avenue Maryland Laurel, 20707 23a. Part 1. Enter the disease, if shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Lymphoma Clarge B (e1) Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam attanding physician and I for usa as tha buriel-trensif The law raquires thet the death cartificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by tha at id ba datached for 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cata has baan sig 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificata has autopsy performed? Yes 2 No 1 ☐ Yes 2 🗹 No 1 🗌 Yes To the Hospitel or Attending Phyalcian: "
within 24 hours aftar death.

To the Funeral Director: Aftar this cartific, complatally filled in by the funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 00057465 29b. Signature and title of certifier MSRajapelselMO 9/20/12

State

P.O. Box 68760

Division of Vital Records,

Registrar DHMH 17 Rev 06-2011 5 763

Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Smith AV

32. Registrar's Signature

NSRUJAPAKSE MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21 Mrinmoy Mukherjee Medical 4a. Facility Name (if not institution, give street and nur. County of Deat Examiner 6/10/ WIME 6. Sex (Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 126-74-4269 1 X M 2 D F 75 December 1, 1936 India Usual Residence of Decedent in than "neture!", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours efter deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Suffolk Commack New York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 Seminole Drive 11725 India 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 x No Specify. Specify: Asian Indian 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer 2+Private permit. Page 1 and 2 should be filed w Department of Health end Mental Hygi Importent: if Item 27 is marked othe eny injury or other treumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Girija Bhushan Mukherjee Bijonlata Mukherjee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ratnakar Mukherjee/Son 6115 Holly Ridge Court, Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place West Arunde L Crematory 20c. Location - City or Town, State September 22 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 AR 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of); Examiner Secue tally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nding physician and use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physicien: The law requires that the death certinues within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buriar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Donpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2/ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) death (Item 23a) (Type, Print) Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g931 9-28-12 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ September Anthony F. Macaione 2012 9:20 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year)
May 16, 1949 **Funeral** Days Min Hours Months 214-54-5169 63 1**₹**] M 2 □ F Maryland Director Usual Residence of Deceder 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director ed other then "neturel", or items 23e or 28e-f e event, the Medical Examiner must be notified 1 X Yes 2 No N/A Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3805 Woodlea avenue 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever in 0.5. Armed Forces? 11 1 Yes 2 1 1 009 − 1970 If Yes, Give 1 909 − 1970 Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by be filed within 72 hours efter Maryland 21215-0036 1 Yes XX No Specify: Specify: White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th Elementary/Secondary (0-12) College (1-4 or 5+) Master Electrician US Coast Guard Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Vincent Macaione Irene Armetta မ permit. Pege 1 and 2 should be Depertment of Health and Man Importent: If Item 27 is marke any injury or other treumetic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gilberte Macaioni/Wife Macaione 3805 Woodlea Avenue Baltimore Maryland 21206 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 9/28/12 Baltimore Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility
Leonard J. Ruck Inc.
Leonard J. Ruck Inc.
Leonard Road Baltimore MD 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Death Immediate Cause (Final INTINGTONS YOARC Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Division of Vital Records, GASTROESOPHAGOAL POFLUX DISCASC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physicien: within 24 hours after deeth.
To the Funeral Director: After this certificy completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{other} \) (Specify) Hospital: ltosa (1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gestiying Figure 1. Section 1. Section 2. Section 2. Section 2. Section 3. Section 2. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. Section 3. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, w dress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEY 2 4 201 Registrar

7

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Carol H. Allan, MD

31. Date filed (Month, Day, Year)

OCME

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lynn 2:32 PM McOueen Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Sattimore rosedale **Funeral** . Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 214-54-3619 1 □ M 2 🔀 F 63 Maryland 11/24/1948 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Baltimore Maryland 1 ☐ Yes 2X No Essex 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 1108 East Riverside Avenue 21221 U.S.A. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mequeen, Vicky Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Wilson, Sr. Pauline Borleis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er) 1226 Damsel Road, Baltimore, Maryland 21221 19a. Informant's Name/Relationship (Type, Print) Pauline Jean Householder (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/22/2012 Baltimore, Maryland 22. Name and Address of Facility nski Funeral Home, P.A. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failu Immediate Cause (Final ck, or heart failure. List only one cause on each line Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 s has autopsy certificate 1 Yes 2 No 1 Yes funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗹 No ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certificate: 27 Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 09/20 2012 91000 Fran Balto. MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Iftikhar A. Malik 0^{Month} 21^{Day} 201^{Y2} 8:046 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery County General Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) 07/10/1938 Birthplace (State or Foreign Country)
 Tradio 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 148-06-7938 74 **Director** India 1 **№** M 2 🗆 F Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Md. Montgomery 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? must be Funeral 20905 15505 Langside Street USA items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Engineering 2Yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever age 1 and 2 should be filent of Health and Mental ort: If item 27 is marked or y or other traumatic ew ပ္ Gul Mohammad Malik Fazal Noor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15505 Langside St. Silver Spring, Md. 20905. Mansor Malik (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1🖎 Burial 2 🗌 Cremation 3 🔲 Removal from State Department of Important: If any injury or 09/24/2012 Sykesville, Md. Lakeview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Athernsclerotic cardiovascular diseas disease or condition Medical resulting in death) Examiner s questially list of allow-if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown End Stage renal disease Were autopsy findings available prior to completion of cause of 24a. Was an death? Director: After this certificate 1 Yes 2 No 1 Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) xaminer? 1 Yes 2 No Hospital: Other: 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 00028429

State

Print) Phyllis Nicholson MB Olney, Maryland 203: 18101 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

September 21,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e Per FH C931 Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MCNEILL Physician/ ESIA SEPTEMBERY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE C 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) 5 / 26 / 61 9. Birthplace (State or Foreign Country)
AL **Funeral** Days Hours 077-54-2146 **Director** 1 🗆 M 2 🛣 F Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10a. State 10b. County 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Numpertomac 10f. Zip Code 21224 10g. Citizen of What Country? 13 N. Funeral St. Potomas Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc.
African
Specify: Armed Forces ģ 1 Never Married 2 K Married within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Amer. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Transportation Elementary/Secondary (0-12) College (1-4 or 5+) Typist III City of Balt. Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Lyles ဂ္ Minnie Isacc permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 N. Potomac St., Balt., MD 21224 Jerome McNeill/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/12 Balt. Cty, MD 4 Donation 5 Other (Specify) King Mem Pk 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service Licensee ^{cility}Hari P. Close F.Svs,PA Rd,Balt.,MD 21206-5105 5126 Belair 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bladder Cancer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Seps:s Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) Day Year To the Hospital or Attending Physician: The law requires that the use within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number SEPTEMBER 20,2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET BALTIMORE MD 21287 1800 ORLEANS Khalil Ibrahim 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State** Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 16:04M ptenber 21, 2012 Robert Thomas O'Brien Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days July 23, 1 🛂 M 2 🗆 F **Director** 150-28-2564 75 New Jersey Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Maryland Harford Belcamp 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4760 Water Park Dr., Unit F 21017 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner: Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles O'Brien Bridgett Bowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda O'Brien (wife) 4760 Water Park Drive, Unit F, Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 9/25/2012 Aberdeen, Maryland 4 Donation 5 Nother (Specify) entombrent Harford Memorial 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ disease or condition Jent Vacu Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe certificate Yes 2 🗌 No 200 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **X**IO 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours affor death.

To the Funeral Director: After completely filled in by ****. 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thea 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) esas 500 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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State of Manyland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryland		tificate o			na ivie	ental Hy	Glene Reg. N	20	12	30445
	Physicia	an/	Decedent's Name (First, ANTHONY	, Middle, Las PARRUCO	,							2. Date of De Month	Da	ay `	Year	3. Time of Death
	Medic Examir		4a. Facility Name (if not ins					4b. City, Town	orloca	ation of D		eptemb		20, 2 c. County of		2:35 p ^M
أميرو			14204 Adkins					Laure		4.1011 0. 5			- 1	,		orge's
	Funeral	Г	5. Social Security Number			(in yrs. iasi	t birthday)	If Under 1 Ye		Jnder 24 ours N	Hrs. 8	B. Date of Bir (Month, Da	Birth 9.			lace (State or Foreign
	Director		120-14-2778 Usual Residence of Dece		XM 2 🗆 F	85	Yrs.			Nov. 1		1926		York		
	and show	ò		County		10c. City,	Town or Loc	ation					-, -			Od. Inside City Limits
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' 0	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by Fu	11. Marital Status1 ☐ Never Married 2	☐ Married	12. Was Decedent Ender Armed Forces? 1 XYes 2 1		l If	Vas Decedent of Yes, specify Co	f Hispani uban, Me	ic Origin? exican, Pu	? (Specif uerto Ric	fy Yes or No- can, etc.)		14. Race - Black,	America White, e	
036	rsafte iral", Exan		3 XX Widowed 4 □ Di		If Yes, Give Year or Dates.		4 V- 0 VII 016							Specify:	Whi	ite
2-0	2 hour "natu adical	plet		Decedent's Ec	lucation de completed)		16a. Deced	ent's Usual Occ			working		16b. F	ustry		
21215-0036	thin 7	Completed	Elementary/Secondary Grade 12		College (1-4 or 5-	life DO NOT use retire					working		T-7	.1		7.0
	ed wi Hygie other ent, tl	Be (17. Father's Name (First, M	fiddle, Last)			PO1.	rce orr	1		Name /	First, Middle,		Surname	on,	DC
Maryland	should be filed within 7. h and Mental Hygiene. 7 is marked other than araumatic event, the Me	မ	Croce Parruc											Surraine)		
ary	hould and M is ma	Catherine Colen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										te, Zip Co	ode)			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Virginia Nov		daughter		8217	Lappin	g Br	ook	Cour	rt La	urel	., Mar	ylar	nd 20723
ore	Page 1 a nent of H ant: If ite ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Crer	mation 3	Removal from State	cen	netery, crem	sition (Name of atory or other p			Dat		20c. L	ocation - C	ity or Tov	vn, State
Baltimore,	it. Pag rtmen rtant: njury		4 Donation 5 0	Other (Specify)	Ft.		oln Cem			/25/	/2012	Bre	ntwoo	d, M	laryland
Ba	permit. Page 1 Department of Important: If it any injury or conce.		21. Signature of Funeral Se	ervice License		0770	22. I	Name and Add Donalds 313 Tal	ress of F on F oott	uner Ave	al F nue	Home, Laur	P.A. ei,	Maryl	.and	20707
			23a. Part 1. Enter the dise shock, or heart failure	ease, or comp re. List only on	lications that caused e cause on each line.	the death. I	Do not enter	r the mode of d	ying, suc	ch as card	diac or r	espiratory ar	rest,			Approximate Interval Between
ata ir	myuician/ Medical		Immediate Cause (Final disease or condition					Syndro	ne						0	Onset and Death
	Examiner	resulting in death) Due to (or as a consequence of):														
	0.26	ner	Sequentially list conditions if any, leading to immediate	te	b. Due to (or as a	consequen	nce of):								-	
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	e exection ar		resulting in death) Last		Due to (or as a	consequen	nce of):									
760	death certificate be executed ne attending physician and ed for use as the burial-transit	edical			d											
89	certifica nding p		IF FEMALE: 23b. Was decedent pregna	ant 2	3c. If yes, outcome o	f pregnanc	у							20d Date	of daline	
Box	eath c atter d for u	Physician/N	in the past 12 months 1 Yes 2 No		1 Live Birth 2 4 Pregnant at			Ectopic pregna Other (specify)						23d. Date of Month		y Day Year
	that the d ned by the e detache	hys	9 Unknown		9 Unknown							1				
	requires that the death certific been signed by the attending should be detached for use a	by F	Part II. Other significant c		ntributing to death bu	t not resulti	ing in the un	derlying cause	given in	Part I.						cause of death?
rds	law requires nas been sign e 2 should be	eted	Cardiomyopa								_	1 🗆 '	Yes 2	X No 3	Proba	ably 4 🗌 Unknown
O O	has b	Completed by	Hypertensio									24a. Was autop	osy	pric	re autops or to com ath?	sy findings available pletion of cause of
ř	Physician: The law this certificate has ral director, page 2		Diabetes Me 25. Was case referred to m									1 Tes	rmed? 2 X N		Yes 2	▼ No
/Ita	s certif	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) XNo	H-	lospital:	- 2 D FF	2/0-44:4		ther:	f Death (C						
ot	g Phy er this neral c		27. Manner of Death		1 Inpatie	/ 28	3b. Time of	28c. In	ury at	∐ Nursin		5 XResid d. Describe h			Specify)	
ou	endin sath. or: Aft he fur	1 X Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No														
Division of Vital Records,	or Atter de lirecto	Certificate:		Could not be determined	28e. Place of Injur building, etc.		e, farm, stree	et, factory, offic	е		28	f. Location (S City or Tow			or Rural F	Route Number,
בֿ	pital o		20a Costiliar 4 VI a	whitesiana Phone	pign: To the best of	au knowl- 1	an destin	on the order	ma -/ -		1					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 2 L Me	edical Examin	cian: To the best of mer: On the basis of exa er: On the basis of exa er: To the	amination ar	nd/or investi	gation, in my op	nion, dea	ath occurr	red at the	e time, date a	nd place	, and due to	the caus	e(s) and manner stated.
	Vithir Withir To the	2	29b. Signature and the of c		C .	LOGE OF THY	ownouge, (29c. Lice			na Pidce			te signed (A		
	1/44	,	1 eppi		عمر ح			D45	660					9-20	2-12	
	101/1		30. Name and address of p					,								
	1 0		Singh Dpind					x Lane	Su	ite 1	124	Bowie	e, M	aryla	nd	20715
	Stat Registra		SEP 2 4	2012	32. Registrar	A.	park	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 30446 Certificate of Death Reg. No. 2 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Sept. Day 2012 Year Isabelle V. Parrette 20 ° 9:36A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4500 Old National Pike Mt. Airy Carroll Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 214-42-1132 Director 1 M 2 X F 78 Maryland 02/14/1934 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. 1 Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13100 Tridelphia Rd. 21042 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Was Deceso... Armed Forces? 1 ☐ Yes 2 📈 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 72 hours after If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify: **Black** Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) 12yrs. College (1-4 or 5+) Hose Cleaning Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Lulu Mae McNair William Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Elijah J. Parrette (Son) 5722 Cedella Ave. Balto.,Md. 21206. Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 09/22/2012 Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Fune all Pervice Licens P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Pulmonary Embolism disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Venous Throbo Embolism 2 vears Sequentially list conditions, Examine day, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death the a 1 ☐ Yes ∠ ya g ☐ Unknown a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 performed? Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 2 **X** No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 To Other (Specify) motel 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending in 24 hours after very he Funeral Director: Aft inhetely filled in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Aurse Practition of the period my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the F 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Maurer, M.D. 2465 Rt. 97 Glenwood, MD 21738

Registrar DHMH 17 Rev 06-201 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18, 2012 3:30 PM Jadanita Marian Rio Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🗆 🛣 Hours 0873171915 97 Mary land **Director** 216-07-7525 Usual Residence of Decedent 28a-f show Dulo be mode...
Id Mental Hygiene.
In arked other than "natural", or items 23a or 28a-1 snover and the than "hadical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1009 Foxwood Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home adanita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence V. Kemp permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Peter J. Ranzino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald T. Kemp (Nephew) 1531 Waterbury Road, Crownsville, Maryland 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cedar Hill Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 09/24/2012 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilitynski Funeral Home, P.A. Signature of Funeral Service 1407 Old Eastern Avenue, Essex, Maryland 21221 rethe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1 or heart failure. List only one cause on each line. interval Between Immediate Cause (Final distass or condition resulting in death) Onset and Death Physician/ Sepsis Medical Due to (or as a consequence of): **Examiner** Severe Anemio Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) Por Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MKHOWE ACNP BE R107529 September 18,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Dr. GlenBurnie MD 21061 Howe ACNP-BG

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical IRENE 06:34 CONSTANCE ROSENKER september 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai of Baltimore BALTIMORE N/A Itospital Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 🗆 M 2 🗶 F 0870571921 Director 214-14-7113 91 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3305 CLARAN ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) SINGER ENTERTAINMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN MOSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK ROSENKER/SON 1626 GREAT FALLS STREET, MCLEAN, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) ARLINGTON NATIONAL : 09/24/2012 FT. MYER, VA 21. Signature of Juneral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) et and Death Physician/ Aspiration neumonia Medical Due to (or as a consequence of) Examiner ysphasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine s a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed demention resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 은 1 Malient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical within 24 hor To the Fune completed fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospita State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifica	te of Death		Re	eg. No.	112 3044			
Physi		Decedent's Name (First, Middle,Last)			2. Date of Dea Month		3. Time of Death				
ledical Exa	mine					Septembe	er 20, 2012	1305 nrs			
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center		4b. City, Town, a Baltimore	or Location of Dea	th	4c. County of	Death			
Funera		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birtho			_		Birthplace (State or Foreign			
Directo	or	216-60-6848 1XM 2 F	60	Yrs. Months Da	ys Hours Mi	^{n.} 04/21,	/1952	Coun M D			
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits			
*	٠.	150	Too. Oily, Town of		_			1 Yes 2 No			
Maryland	at onc	MD n/a		Baltimore	e		Og. Citizen of Wha				
ne Ma	Director	4221 Pascal Avenue		i '	1226	'	USA	it Country :			
with th			Ever in U.S.	13. Was Decedent of H		Specify Yes or No		American Indian, Black,			
Jeath r iten	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	X No	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	White,				
after all", o	by F			1 Yes 2 X N	lo specify:		Specify:B	lack			
hours		15. Decedent's Education (Specify only highest grade com	du	ecedent's Usual Occup			16b. Kind of Busi	iness/Industry			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a nr 28a-f she	Completed	Elementary/Secondary (0-12) College (1-4 or 9	5+)	ght Stocke:		,	Safeway	Grocery			
5-00; lled withi Hygiene.		17. Father's Name (First, Middle, Last)		gire becere.		ne (First, Middle, f		drocery			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C				Hazel Si		vialacii (arianic)				
21218 hould be fill and Mental H	o ا ہ	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Stre				State, Zip Code)			
e, MD		Kimberly Raikes / Wife		21 Pascal A		imore, M	D 21226				
ore, es l an of Hea If iter	niner traumatic	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	te cremator	Disposition (Name of c y or other place)		Date	i	City or Town, State			
imore Pages 1 ment of H		Donation 5 Other Specify:	Cremat	ion Ctr of	MD 9.3	24.2012	Hanover	, MD			
Baltimore, permit. Pages 1 ar Department of Hee	canfur .	2). Signature of Funeral Service Littensee	À	22 Name and Addre John L. W 4517 Park	ssofficility illiams I	Funeral	Director	s, P.A.			
Physicia	n	23a. 1. Enter the disease, or complications the course	eath. Do not	enter the mode of dying	g, such as cardiac	or respiratory arre	est, shock, or hear	t Approximate Interval			
/Medica		Immediate Cause (Final disease a. Metformin	l Drug an Netopr	d Alcohol	Intoxica	tion(Gli d Varden	mepiride afil)	Between Onset and Death			
Examine	31	or condition resulting in death) Due to (or as a conse		oror, varo	urtun un	u varaci					
	<u></u>	Securitiesly list nonditions b. b. if any, leading to immediate Due to (or as a conse	rayonaa of):			-					
	l ii	cause. Enter Underlying Cause (Disease or injury that initiated									
ъ .	Xa	events resulting in death) Last Due to (or as a consequence of):									
Box 68760, death certificate be executed the attending physician and			s noted.	23a,27,28a	-f per m	e g932 1	0-3-12 v	t			
760, icate be	/Medical	IF FEMALE: 23c, If yes, outcome			F	- 6	23d. Date of d				
		1200. Was decedent pregnant in the	2	Fetal death 3	Ectopic pregn	ancy	Month	Day Year			
Box 68's death certification of former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an annual former and an another an an annual former and an another an an annual former and an another an an an an an an an an an an an an an	Physiciar	1 Yes 2 No 9 Unknown	time of death 5	Other (Specify)							
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ing Physician: The law requires that the After this certificate has been signed by human and dispendent manages, a beyond the dependent manages of the order of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of th	A A					1 Yes	2 No 3	Probably 4 V Unknown			
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Division of Vital Records, spital or Attending Physician: The law require ours after death. reral Director: After this certificate has been signed in by the financy disperse needs the characteristics.	Certification:	3 X Suicide 6 Could not be 28e. Place of Inj		n, street, factory, office	building, etc.	28f. Location (S or Town, S	Street and Number tate) 4221 I	or Rural Route Number, City			
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Division of Vital To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director. After this cert	Medical	(Check only one) 2 Medical Examiner: On the basis of exam									
To Wit	Me	and manner stated. 29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, Day, Year)			
		11-(1111)	P. D	0.C	.M.E.		September 2	21, 2012			
		30. Name and address of person who completed cause of de	eath (Item 23a))							
		Zabiullah Ali, M.D. Assistant Medical Ex	aminer 900	W. Baltimore Str	eet, Baltimore	, MD 21223					
	State		-	bares							

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER TANY ROOKS 19:32P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) Director 216-41-4510 Maryland March Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NIA 1 Nes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 idgecro 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) jerver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unthia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kidgecroft" Kd. 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or Baltomore audon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee well Ue It MEG Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Gliobastoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in listed as on the cause (Disease or injury that in listed as on the cause (Disease or injury that in listed as on the cause (Disease or injury that in listed as on the cause (Disease or injury that in listed as on the cause (Disease or injury that in listed as on the cause (Disease or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that in listed or injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury that injury tha Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 1 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5
Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie RES-000 SEPTEMBER 12 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS STREET BALTIMORE ND 21287 MC Date filed (Month, Day, Year) State

Registrar

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	requires that the death certificate been signed by the attending physishould be detached for use as the t	Completed by Physician/Medic	1 Yes 2 9 Unknown		9 Unkr	nant at time of nown	death	5 Other	(ѕресіту)								1001
7.0.	es that igned to be det	b P	Part II. Other signif	ficant conditions	contributing to d	eath but not re	sulting in t	he underlyin	g cause giv	en in Part	l.				ribute to th		
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			For State Registrar	State of Ma	aryland	-	artment of H tificate of D		nd Mental Hy	/giene Reg. No. ⁽	2012	30452
	Physicia Medic		1. Decedent's Name (First, Middle, La	Ph					2. Pate of D		20+2	3. Time of Death
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المحمد	Funeral		Seasons Hospice a 5. Social Security Number 6. S	Sex 7. Age	e (In yrs. las		Randa1 If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi			thplace (State or Foreign
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	aryland a-f sho fied at	ector	10a. State 10b. County MD Carro	11		Town or Loc kesvil						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
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Mary	or and z should be file of Health and Mental F filem 27 is marked o r other traumatic eve	·	Gaston Stickele 19a. Informant's Name/Relationship (Susan Shipp — d	Type, Print)			•	and Number o	r Rural Route Numbi	er, City or To		o Code)
Baltimore,	permit. Page 1 an Department of He Important: If iterr any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Spec			metery, crem	sition (Name of latory or other place		Date		Town, State	
Ball	Depart Import any inj		21. Signature of Funeral Service Licer Danyle 1 A.	Naylor		22.			State Ana re St; Ba			21201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sep Lencher Physician/ Stavou 1:15 PM 4 wthow 172012 Medical 4a. Facility Name (if not institution, give street and number) Apt 414 4b. City, Town, or Location of Death Examiner Baltimore Cit HUE Arlington Bal HINCRE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign N. Courarolina **Funeral** 212 56 8098 Days Hours Min. 03 Mpmth 4Pg/, 1/99/51 Director Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD N/A Baltimore 1 🖾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 701 N. Arlington Apt 414 21217 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes, 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married Completed by Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 12th Grade College (1-4 or 5+) Security Guard unk other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve anse. မ George Scales Olivia Scales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Madison(mother) 4853 Reisterstown Rd., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State on-site Crematory09/19/12 Baltimore, MD 4 Donation 5 Other (Specify) . Signatur of F rvice License 27岁罗哈所伊罗哲伊wn Jr. Funeral Home 2440 N. Fulton Ave., Baltimore, i PA MD 21217 Þ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DAKES CONLC-Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury eure O bes To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Nea 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 100 Wat 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ė 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Certifica 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier aucol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Ravon Block Baltimons 21218

State Registrar Kalle

Mouross 31. Date filed (Month, Day, Year) CHOP

3900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 19 2012 Physician/ 6:51PM John T. Sindall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 219-10-8372 Director 1 🖾 M 2 🗆 F Feb 19, 1926 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Earlton Road 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Mantal Status 14 Race - American Indian Black, White, etc. 9 þ 1 Never Married 2 X Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sindall John (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than 'ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Central Office Foreman Bell Atlantic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Truman Sinda11 Mark Lilliam Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Sindall 704 Earlton Road Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 9/24/2012 Reisterstown, MD Signature of Euneral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME 21136 Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pulmonary Onset and Death Physician/ hour Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Myelodysplasia 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 1 No the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 - No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DOO 43 48 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brigh Behren
6535 N, Charles St. Sy, 550 Jourson N 21204 31. Date filed (Month, Day, Year SEP 2 4 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical ETEMBER 18 2012 Julia Black Scaggs 4.451 M Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death GLEN BURNIE DACTI MOZE WASHINGTON MEDICAL MER 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 577-18-1438 1 🗆 M 2 🗓 F 92 Usual Residence of Decedent 16, 1920West Virginia Sept. ?7 is marked other than "natural", or itema 23a or 28a-f show traumetic event, the Wedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Maryland 1 Yes 2 X No Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4501 Yucca Street 20705 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. parmit. Paga 1 end 2 should ba filed within 72 hours aftar Department of Haalth and Mantal Hygiane.

Important: If item 27 is marked other than "natural", or eny injury or other traumetic event. The Market and Once. Black, White, etc. 1 Never Married 2 Married ۾ Manyland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) United States 12 Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walker Black Julia Amanda Roby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Scaggs / Daughter LeCompte Lane Davidsonville, Maryland 21035 2604 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Sept. 2012 20, Arundel Crematory 4 Donation 5 Other (Specify) W. Odenton, Maryland Signature of Funeral Service Lie Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CHASTRIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TILNTESTIN Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: Tha law raquires that the daath cartificata ba axacutad use as the buriel-transit and that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law required to the attending physician within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam.
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be B 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) |요 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending ☐ Accident 1 Tes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2nd Date sinned (Month, Day, Y (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) and tur 29b. Signator 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BNAGATO 31. Date filed (Month, Day, Year) 32. Reg Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:56 AM reptember 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Raven Baltimore Baltimore Genesis Loch Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days April 7, 1943 1 - M 2X-X Months Hours 69 Mary land 220-42-8337 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Parkville Maryland **Baltimore** 1 🗌 Yes 2 🎑 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 Linwood Road er than "natural", or items 23a the Medical Examiner must be 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Insurance permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Steffey Doris Wessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 Linwood Road Parkville MD 21234 Timothy Steffey/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Hillton Service Corp. 9/24/12 Hilltop Servcie Corp. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License ^{22 Name and Address of Facility}, Inc. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 21214 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ tor: After this certificate has been signed by the atterthe funeral director, page 2 should be detached for it in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 2 🔲 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Division of Vital Records, P.O. Box 68760

6095 enning 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

alle

29d. Date signed (Month, Day, Year)

Drive Felkridge, Md. 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 19, Ralph H. Sheldon 8:15 pm 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Arden Court 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 101-12-8411 1 🕱 M 2 🗆 F 89 10/12/1922 New York or 28a-f show ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12745 Bexley Terrace 20904 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 □ Divorced Specify WWII Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry N. Schmuck Elizabeth May Decker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Wood - Daughter 12745 Bexley Terrace, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 09/24/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M01355 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
5 Years Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Enter the light Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy5 Other (specify) Pregnant at time of death Month Dav Year signed by the a ld be detached i 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2: performed? death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted examiner? Hospital 2**X** No Other: 1 🗌 Yes ည 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 20, 2012 D43237

State Registrar

DHMH 17 Rev 06-2011

14201 Laurel Park Drive, #102, Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Armstrong,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rnest Henry To	OFDI	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012 304	5
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at for		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral		601 E. Chase Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
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e Maryl or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 448 SANDAL(2)(200) RAD (21221 U.S.A.	
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21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Be	William Burgess SADIE TORBIT	
	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Z122 LA TOVA TORBIT/WIFE 948 SANDALWOOD RL. ESSEX, MARVIAND	./
_ = # # 21		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
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Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Fagilie DERRICK C. JONES FIH, P. A.	7.
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pheompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	\exists
		O.C.M.E. September 16, 2012	
\mathbb{Q}		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	2
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 4 2012 32. Registrar's Signature	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month : 30AM Turchin September Physician/ George Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 09/08/1949 **Funeral** Pennsylvania 1 🔀 M 2 🗆 F 63 Director 216 52 4963 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number United States 21220 Funeral 204 Riverthorn Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mobile Office Mfg. Master Carpenter 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked or any linjury or other traumatic evel once. Oroski Veronica John A. Turchin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 204 Riverthorn Road Middle River Maryland 21220 Donna Turchin (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Baltimore Maryland Bayview Crematory Inc 9/21/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sig to be of Fyneral Service Licenses 1407 Old Eastern Avenue Essex Maryland 21221 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failur). List only one cause on each line. Part . Enter the dis Interval Between Onset and Death Immediate Cause (Final diseane or condition resulting in death) Neck Cancer Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23b. Was decedent pregnant Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 □ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Be examiner? 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 5 Pending 1 ☐ Yes 2 ☐ No 1 Natural Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be 3 Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nslly aparal MD 9/21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLON Bumie 6934 Aviation Blip NSRajapaksemo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Teplica, Joseph

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1			30. Name and address of person who	completed cause of a	death (Item 2	3a) (Type, P	rint)		-	-	Ve Ro			M	0 712	7317
	Stat Registra	е	31. Date filed (Month, Day; Year) SEP 2 4 2012	32. Registr	ar's Signatur	park		6.0	ے ۱	J 1	ve. Ba	. (11		, ,	- U16	~ /

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ o Month idney **4**M 20/2 Medical 4a. Facility Name (if not institution, give street ar **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Secours Himore Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗖 M 2 🗆 F Hours 07/24/1958 Director 212-80-4862 54 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2920 Virginia Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 X Married Completed by 1 Yes : 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: SpecifyBlack 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other trainmain. College (1-4 or 5+) Elementary/Seconday (0-12) P&J Contracting Diesel Mechanic/Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edward Tuggle Doris Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Parker-Tuggle / Wife 3006 Virginia Ave Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cremation Ctr of MD Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify) 9.24.2012 Hanover, MD 4 Donati 21. Sign ture of Funeral Se John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 Athter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death shoo Immediat Cause (Fi disease condition resulting in death) Cause (Final Physician/ Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Directoralth.

To the Funeral Directoral this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director, page 2 should be detached for use as the bundleted filled in by the funeral director. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 1 Yes မ 1 Inpatient 2 IER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 V Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secours Hospital Sherren Benn-Thompson 2000 W. Baltimore St

Attending

physician

DHMH 17 Rev 7/2009

29c. License number

D0063545

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Funeral Director		215-74-6266	6. Sex 7. Ag	ge (in yrs. ii	ast birthday)	Months	Days	Hours	Min.	8. Date of Bi (Month, D			Coun		reign
		Usual Residence of Decedent	1 L W 2 / L	52	Yrs.					07/20/	196	0	NAR	YIAND	
fand show	5	10a. State 10b. County		10c. Cit	y, Town or Lo								1	0d. Inside City Lir	
che Maryland or 28a-f sho	<u> </u>	MD			BAL	Time	ORE							1 Yes 2	□No
th the	<u>a</u>	10e. Street and Number	0			10f. Zip		. ~			10g. (Citizen of W		•	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at proces.	runeral	3419 SPEZ	LMAN RO		2 112 1	Mas Doogs		12 	ain? (Coo	cify Yes or No			5,A		
ter de:		1 Never Married 2 Marri	Armed Forces?			If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	Rican, etc.)			, White,	an Indian, etc.	
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.	ב ב	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			1 🗌 Yes	2 No	Specify:				Specify:	BC	ACK	
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within 73 within 73 giene.	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. D	O NOT use	retired)	-			IA	EDI	CAL		
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yland IId be filed Mental Hy narked oth	2		VINSON							e (First, Middle	, Maide	n sumame, Ros			
ould he mark	ŀ	19a. Informant's Name/Relationshi			19h Maili	na Address	(Street a		EL.		er City			Code) 2/2	1.3
M 12 sh aith ai			SON/MOTH	ER	232									EV/AND	
other	ŀ	20a. Method of Disposition	•	20b. F	Place of Dispo	sition (Nan	ne of			Date	20c.	Location -	City or To	wn, State	,
imo Page nent c ant: If		1 ☐ Burial 2 💢 Cremation 4 ☐ Donation 5 ☐ Other (S)		, I	remetery, crer TRO CA			- 1	09/2	9 2012	BA	Timo	eE, h	MARYIAZ	··l
Baltimore, permit. Page 1 and Department of Hes Important: If item Important: If item any injury or othe and in the sunce.	Ì	21. Signature of Funeral Service Li	censee	10.10		2. Name an			_	DER	RIC	Ke.	JUN	VES FIN	(P.A
m 89		Werney	C. Jo	رن ح	- 4	611 P	ARIC	Hat	5.A	VE., B	AL	Timor	EIN	ARVIA	Sud
200		23a. Part 1. Enter the disease, or eshock, or heart failure. List or			h. Do not ente	er the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between	
Pnysician/	ı	Immediate Cause (Final disease or condition	- a - Stre	ke									10	Onset and Death	ו
Medical Examiner	-	resulting in death)	Due to (or as												
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tal Records, P.O. Box 68760 clan: The law requires that the death certificate tertificate the speed speed by the attending physicion, page 2 should be detached for use as the Bocompleted by Divisional Medical		F FEMALE:										7	1		
X 6 X 6 Ith cert the cert then use or use		23b. Was decedent pregnant in the past 12, months?	23c. If yes, outcome	of pregna	incy aldeath 3 [Ectopic p	pregnanc	ÿ				23d. Date			
Bo Bo B dea the a the a	<u> </u>	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of o	death 5L	Other (sp	pecify)					Mor	iuri	Day Year	
P.O. That the ned by a detact		Part II. Other significant condition	ns contributing to death I	out not res	ulting in the u	underlying o	cause giv	en in Part	l.	23e. Did	tobacco	use contri	bute to th	e cause of death	?
S, IS, Isign III be lid be	2									1 🗆	Yes	2 🗌 No	3 Prot	ably 4 🗌 Unkn	nown
oro v requ										24a. Was	an	24b. W	ere auto	osy findings availa	able
Recorded to the law age 2		10-1-4-10-10-41								auto perl 1 🗆 Yes	opsy ormod? 2	p d	rior to co eath? Yes	npletion of cause	of
al F		25. Was case referred to medical					26. Pl	ace of Dea	th (Check		40	NO] I	□ ies	2 LI NO	
of Vital Record of Vital Record g Physician: The law request this certificate has been neral director, page 2 should be complete.		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatie	nt 3 ☐ DO	Othe	er: 4 🗆 No	ursing Ho	me_5 🔲 Res	idence	6 Othe	(Specify	hospice	
n of Vitalian of Mina Physic of Afferthis ce	<u>i</u>	27. Manner of Death 1 № Natural 5 □ Pending	28a. Date of inju (Month, Da	ury i <i>y, Year</i>)	28b. Time of injury	f 2	8c. Injury work	?	- 1	28d. Describe	how inju	ury occurre	d		
vision or Attendin firer death. in by the fu		1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n	ation			М		Yes 2	No						
		4 Homicide determi	28e. Place of Inj building, et	ury - At ho c. <i>(Specify</i>	me, farm, str	eet, factory	, office			28f. Location City or To			r or Rural	Route Number,	
he Hospita in 24 hours he Funeral ppletely filled	מוכם		Physician: To the best of caminer: On the basis of c												etated
The H		only one) 3 Certifying	Nurse Practitioner: To the			, death occi	urred at t	he time, da							stated.
v v vit		29b. Signature and title of certifier	LVS.			290	-	number				ate signed			17
	-	10.0			-0.1-		ソ	283	03		>	GIRCH	العوا	19 201	
7		30. Name and address of person w	ho completed cause of c	peath (Item	(Type, F	rint)	che	nles	(T	Tonis	أره	M)		
State		31. Date filed (Month, Apr. 1791)	32. Registr	ar's Side	cola				- J	1004.		,	,		
Registrar		SEP 24 CUIL	Comment La.												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ula Willierspeen	1- For State Registrar	Certificate of	f Death	Reg. No	. 2012	3046				
Physician/	Decedent's Name (First, Middle,Last)	0.0		2. Date of Death Month Day September 17	Year	3. Time of Death				
Medical Examine	Eula A. Witherspo 4a. Facility Name (if not institution, give street an		4b. City, Town, or Location of Dea		4c. County of Death					
A	University Hospital		Baltimore		N/A					
Funeral Director	5. Social Security Number 6. Sex 1 1 M 2 X	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi Months Days Hours Mi	_ `	W/DD/YYYY) 9. Birth Foreign Cour					
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	tion		1	Od, Inside City Limits				
faryland 15s-f show 1 at ouce. ector	MD N/A		Baltimore			1 Yes 2 No				
th the Maryland 23a or 28a-f sho motified at once.			10f, Zip Code 21207		itizen of What Countr U . S . A .					
er death wi , or items r must be		ed Forces? If Y	as Decedent of Hispanic Origin? (\$ /es, specify Cuban, Mexican, Puert Yes 2 XNo specify:		14. Race - America White, etc. Specify: Bla	an Indian, Black,				
ours aft	or Dates:	grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of	work done 16b	Kind of Business/Ind Mercy Med	dustry di cal				
5-0036 et within 72 hour sygiene. other than "natur he Medical Exar	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	stered Nurse	, indu	Center	arcar				
215-0036 be filed within 72 rited wither than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the other than the o	17. Father's Name (First, Middle, Last)	1109-	18.Mother's Nam	ne (First, Middle, Maide	n Surname)					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Willard Witherspoo		Mary							
s, MD 21 and 2 should feath and Me tem 27 is ma traumatic ev	19a. Informant's Name/Relationship (Type, Print Michele Thompson(s	1	g Address (Street and Number or Oak Ave., Ba							
re, MC 1 and 2 si Health ar Fitem 27	20a. Method of Disposition 1 X Buriet 2 Cremation 3 Remove	20b. Place of Dispos	sition (Name of cemetery,	Date 200	. Location - City or To	own, State				
Baltimore, bernit. Pages I an Department of Hei Important: If ite	4 Donation 5 Other Specify:	Woodlaw	n Cem. 09	/22/12 Ba						
Baltimo permit. Page Department of Important: injury or out	21. Sign ture of Funeral Service Lib. n	21	ชร ะชา เด็ก คราช พาก 40 N. Fulton	Ave., Bal	ltimore,	PA MD21217 Approximate Interval				
Physician	23a. Part I. Enter the disease or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Examiner		c Shock complicate as a consequence of):	ating Abdominal	Liposuctio	n	Death				
Service (1)	Sequentially list conditions, b.	0				*				
ted nisit r	if any, leading to immediate Due to (or cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of):			; 4					
ted d ansit		as a consequence of):								
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lox 68760, eath certificate be exertending physician for use as the burial.		ves, outcome of pregnancy	etal death 3 Ectopic pregr		3d. Date of delivery Month Da	y Y ear				
Box 687 death certific the attending p ed for use as th	past 12 months?	roanant at time of death	etal death 3Ectopic pregr ther (Specify)	iancy	Month Da	y 16ai				
the death certific the death certific by the attending I ched for use as the Physician/	1 Yes 2 No 9 ✓ Unknown 9 U	ng to death but not resulting in the	underlying cause given in Part I	23e. Did tobacc	o use contribute to th	e cause of death?				
, P.O. B res that the d signed by the be detached by Dhy		ing to doday but not robuiting in the t	arraonymy caace great mir act.		No 3 Probal					
Records, The law requires fricate has been signage 2 should be Completed				24a. Was an autopsy		psy findings available mpletion of cause of				
Reco				performed?	? death? No 1 ✓ Yes	2 No				
Vital Rec ysician: The I his certificate I director, page	25. Was case reterred to medical examiner? [Hospital: . r	✓ Inpatient 2 ER/Outpatient	26.Place of Death (Check t 3 DOA Other Nurs		dence 6 Other:					
n of Vi ding Physi After this funeral dir	27 Manner of Death 28a (Inpatient 2 ER/Outpatient Date of Injury Month, Day, Year) ER/Outpatient 28b. Time of I		28d. Describe how in						
ion frendin leath. for: A the fur	1 X Natural 5 Pending 2 Accident Investigation	nontri, Day, 1 ear)	1 Yes 2 No							
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been s setly filled in by the funeral director, page 2 should I al Certification: To Be Completee.	3 Suicide 6 Could not be determined (Spe	Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Street or Town, State)	and Number or Rura	Route Number, City				
Hospit 24 hour Funera Funera	129a Centrer	e best of my knowledge, death occur	rred at the time, date and place, an	d due to the cause(s) a	and manner as stated					
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	one) 2 Medical Examiner: On the ba	asis of examination and/or investiga ner stated.	tion, in my opinion, death occurred	at the time, date and p	place, and due to the	cause(s)				
2	29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Young) O.C.M.E. September 18, 2012							
Ø	30. Name and address of person who completed	cause of death (Item 23a)								
	Ana Rubio M.D., Ph. D. Assista	nt Medical Examiner 900	W. Baltimore Street, Balt	imore, MD 21223						
State Registra	0 C D O A 0010 A	2. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 21 Physician/ 2012 4:20 AM James McCormick Webster Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours 001-28-0037 Director 1**X** M 2 □ F 75 March 30, 1937 Maryland Usual Residence of Deceder ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hyglene. al Hyglene. Director Baltimore 1 XX Yes 2 I No Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 5912 Charlesmead Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates, 1959-61 Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) insurance insurance agent it. Pege 1 and 2 should be filed with timent of Heelth and Mantal Hyglen rent: If item 27 is marked other in jury or other traumatic event, in Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Lee James McCormick Webster Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Webster/wife 21212 Baltimore, MD 5912 Charlesmead Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State permit. Pege Department of Importent: If any Injury or once, Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory 22. 2012 Sep. 21. Signature of Funeral Service Licensee Name and Address of Facility York Rd Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Error Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transi ed by the attending physician and detached for use as the burlal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify WOSPL CL 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A Description of the basis of examination and/or investination in my oninion death occurred at the time.] Medical 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty re and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST CHARLES HARON 701 31. Date filed (Mohth, Day, Year) 2

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2

State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9:30 pm Physician/ 19, 2012 Warrington, Sept George Vernon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Reisterstown 706 Berrymans Lane If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Months Days Hours **Director** 215-30-4289 1 X M 2 - F Yrs. 76 10, 1936 April Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the Medical Examiner must be notified at any injury or other traumatic and the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County Director 1 Yes 2 X No MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21136 706 Berrymans Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wholesale Food Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Holsten Margaret ٧. Warrington, Sr. George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Berrymans Lane Reisterstown, MD Wife Nancy Warrington 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Reisterstown, Maryland Reisterstown U.M Cem 9/22/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee 11824 Reisterstown Road 21136 ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onser and Death Immediate Cause (Final Physician/ lin disease or condition Medical resulting in death) Due to (or as a conseque e of) Examiner Sequentially list conditions, if any leading to train clothe cause. Enter Underlying Examiner Due to jor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Year Pregnant at time of death 1 Yes 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes 2 🕒 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 1 Yes n 24 hours after œea...
ne Funeral Director: After th 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work 1 / Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioper To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of 20806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HTRICK RNUS 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First, Middle, Last 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give st **Examiner** Prince Geo 4b. City, Town, or Location of Death aur **Funeral** (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Hours Min. **Director** 117-20-1910 1 🔀 M 2 🗆 F 83 Feb. 13,1929 New York iral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1X Yes 2 No Niagara North Tonawanda 10e. Street and Number 10g, Citizen of What Country? 699 Christiana Street 14120 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 X Yes 2 No 1948 If Yes, Give 1952 Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1952 Completed 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Civil Engineer & Elementary/Secondary (0-12) College (1-4 or 5+) 12th Engineer Land Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilfred I. Watson Irene (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jan Ellen Rustin/Daughter 9142 Bryant Avenue Laurel MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State \square Burial 2XXCremation 3 \square Removal from State 4 Donation 5 Cther (Specify) West Arundel Crem. 9/20/2012 Odenton, MD . Signatur of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott ter the disease, or complications that caused heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, o heart failt Immediate Cause (Final Interval Between Physician Onset and Death disease or condition resulting in death) Decubitus Ulcer Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and deed be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury Dehydration that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Confusion 1 Tes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy perform death? 1 ☐ Yes 2 XXNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cther: 4 Nursing Home 5 Residence 6 Cther (Specify) ဂ္ 2 X No X Inpatient 2 ☐ ER/Cutpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying, Nurse Practitioner: To the best of my knowled and death occurred at the time, date and date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time, date and due to the best of my knowled and death occurred at the time. Signatu signed (Month, 29d. Date

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

SEP 2

4700 Van Dusen Road, Laurel,

MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Malik,

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 18 Barbara B. Whittle 4:25 am 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3317 Solomon Court Silver Spring Montgomery Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year If Under 24 Hrs. (Month, Day, Year) Hours Min. 579-30-2484 1 □ M 2 🕱 F Yrs 85 08/23/1927 Utah 10c. City, Town or Location 10d. Inside City Limits Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3317 Solomon Court 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Booke Alta Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5208 NE 251st Avenue, Vancouver, Washington 98682 Craig Whittle - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Ponation 5 Other (Specify) Fairview Cemetery 09/24/2012 Preston, Idaho 21. E gnal re of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Provician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

ပ

Examiner

Funeral

Director

28a-f shov

nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at

be filed within 72 hours after death with the Maryland

physician and sthe burial-trans use as signed by the a page, funeral director, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

The law requires that the death certificate be

To the Hospital or Attending Physician:

atten for u

Division of Vital Records, P.O. Box 68760

	Juny Mit	- MO0109	11800	New Hampshir	e Ave., S	silve	r Spriv	19,MD 2	0904		
	23a. Part 1. Enter the disease, or compli shock, or healthailure. List only one	ications that caused the death. e cause on each line.		· · · · · · · · · · · · · · · · · · ·				Approxim Interval Be	ate		
	Immediate Cause (Final disease or condition resulting in death)	a. Kidney Can						Onset and 2 Yea	Death //S		
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					_	_		
edic		j			· · · · · · · · · · · · · · · · · · ·						
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No g □ Unknown	3d. Date of de Month	elivery Day	Year							
ed by PI	Part II. Other significant conditions con		te to the cause of death? Probably 4 Unknown								
complet							prior to death?	utopsy findings completion of s 2 \(\sime\) No	available cause of		
	25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)						
lo Be	1 🗆 Yes 2 💢 No	lospital: 1 Inpatient 2 E	R/Outpatient 3	☐ DOA Other: 4 ☐ Nursing	Home 5 X Res	idence 6	Other (Spec	cify)			
Certificate:	27. Manner of Death 1 Natural 5 □ Pending Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1									
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fac	ctory, office		Location (Street and Number or Rural Route Number, City or Town, State)					
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier			29c. License number		29d. Date	signed (Mont	h, Day, Year)			
	1/1X/22			OATEGE	I						

D45880

655 Watkins Mill Road, Gaithersburg, Maryland 20879

September 19, 2012

DHMH 17 Rev 06-2011

State

Registrar

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

M.D.,

Leon Hwang, 31. Date filed (Month, Day, Year)

SEP 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25 PER ME G931 9/20/12 TRT/ Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanor D. Yorker 2012 August AM Medical 10:01 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year, 219-30-9525 Director 1 M 2 X F 81 1/9/1931 MD 28a-f show with the Maryland at 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified N/A Baltimore MD 1 X Yes 2 No 10e. Street and Number ritems 23a or iner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Carswell St. 21218 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or than "natural", or iter the Medical Examiner Black, White, etc 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th University Of MD Housekeeper 17. Father's Name (First, Middle, Last) Unknown of Health and Mental H f item 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor W. Yorker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; if item 27 is any injury or other trau once. 1603 Carswell St. Baltimore, MD 21218 Maria Yorker- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State Baltimore, 4 Donation 5 Other (Specify) Site Crematory 8/22/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East QN E. North Ave. Baltimore, MD 21202 1101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis secondary to Pneumonia Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 48 hrs Injury Kidney 9tule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMI Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year detached the g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director. After this certificate becompletely filled in by the funeral director, page Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Inpatient 2 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 AT 2438946 August 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Union 31. Date filed (Month, Day, Year) State 32 Aegistrar's Signature **SEP 24** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30469 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 2, 12:01 A M ^D2012 ERNEST ADRIEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Wheaton Montgomery 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) Days 77 Hours 129-44-3247 Director 1 **K** M 2 □ F Apr. 13, 1935 Haiti Usual Residence of Dece 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? 23a 20904 USA 14105 Castle Blvd, Apt. 102 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces?
1 ☐ Yes 2 █ No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", **Black** 3 Widowed 4 L Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Mechanic Auto other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Eugenia Paul permit. Page 1 and 2 should be Det artment of Health and Ment Important: If item 27 is marke any injury or other traumatic eonce. Duquernest Adrien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14105 Castle Blvd., Apt. 102, Silver Spring, MD Patrick Adrien / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State Pinelawn Cemetery 9/8/2012 Long Island, NY 4 ☐ Donation 5 ☐ Other (Specify) Beall Funeral Home Signat re of Funeral Sc 22. Name and Address of Facility 6512 NW Crain Hwy.. Bowie, MD 20715 Part 1. Enter the dispuse of shock, or beart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure to thrive Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause Er ter chaerlying Cause (Disease or injury that initiated events Exami burial-tran and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 24 hours after death Funeral Director: A 1 Yes 2 No Investigation 6 Could not be 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP 06 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.

Registrar's Signatu

20056132

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Medical <u>Eva</u> Burch 7:45 A Joyce 2012 September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 26545 North Sandgates Road Mechanicsville Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 213-38-3175 1 □ M 2 **X** F 84 Usual Residence of Decedent 02/05/1928 New York 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Mechanicsville St. Mary's 9 10e. Street and Number 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 26545 North Sandgates Road 20659 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify 'natural", Specify: White Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12th Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မှ Clarence Newell Frances Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 26545 North Sandgates Rd., Mechanicsville, MD 20659 <u> Vernon Burch/Son</u> other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ō Department of Important: If i any injury or conce. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/13/2012 Mechanicsville, MD Zion UMC Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Veryton MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal fullur ∘Ph iin disease or condition meeks Medical resulting in death) Due to (or as a consequence of): Examiner Bladder concer months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5√ Residence 6 ☐ Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury s after death. 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death within 2 occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) m'D D0068120 9/10/12

(G)RME s

State Registrar Minal Shah, M.D., 23415 Three Notch Rd., California, MD 20619

31. Date filed (Month, Day, Year)

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certifi	icate of Death		Reg.	No.	2 3041
Physi		Decedent's Name (First, Middle,Last)				2. Date of Death Month	ay Year	3. Time of Death
Medical Exa	mine	DCIVIII D. DIGITO				September 4	4, 2012	1615 hrs
		4a. Facility Name (if not institution, give street	eet and number)	Annapolis	or Location of Deatl	n	4c, County of Death Anne Arundel	
Funer	eal .	Social Security Number	7, Age (In yrs. last t			s. 8. Date of Birth	MM/DD/YYYY) 9. Birtl	nplace (State or
Directo					ays Hours Mir	Sent 20) 1966 Ma	mwland
`	-	Usual Residence of Decedent	2	13 113.		Pepo z	7 1 3 0 0 114	24 2 411 4
япу		10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits
nd show	2	Maryland Anne Ar	ındel Ann	apolis				1 Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number	<u> </u>	10f. Zip Code	_	10g.	Citizen of What Coun	try?
hours after death with the Maryland natural", or items 23a or 28a-f sho		94 Clay St.		21	401		USA	
h with	Funeral	11. Marital Status 1 X Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	lispanic Origin? (S an, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
r deat		1	Yes 2 X No			Tribun, ordry	D1	ack
rs afte	至	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:	1 Yes 2 X N		work done	Specify: BL 8b. Kind of Business/Ir	
2 hour	the Medical Examin Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working li		ired)	Sheldon G	reen
336 thin 72 re.	giga D	10th	O	Landscapi	ng	I	Landscapi	ng
215-0036 be filed within intal Hygiene.	C Ihe M	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle, Mai	den Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be if	James Blunt			Terry			
	일	19a. Informant's Name/Relationship (Type	19	19b. Mailing Address (Str				
Baltimore, MD bermit. Pages I and 2 sho Department of Health and Important: If item 27 is	or other traumatic	Terry Wright (Mo		1125 Madis			Annapolis Oc. Location - City or 1	
ore, of He If ite		1 Burial 2 XCremation 3	Removal from State crem	natory or other place)			-	
Baltimo permit. Page Department o	5	4 Donation 5 Other Specify:	Metr	o Cremator	4	19-12	Baltimor	
Ball Sermit Depart	[]	21. Signature of Funeral Service Licensee					uary, P.A	
Physicia		23a. Part I, Enter the disease, or complicate	ons that caused the death. Do				olis, Md.	21401 Approximate Interval
Medic		failure. List only one cause on each li	ne.					Between Onset and Death
Examine	er		rdiomegaly and to (or as a consequence of):	Atheroscler	otic Card	liovascul	ar Disease	
	١.	Sequentially list conditions, b						
	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of):					
	_]	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):					
760, Greate be executed physician and	trans	d						
D, be exe	he burnal - tra	X UNPENDED A	nended 23a, 27, per	r me,g931 9-2	28-12 sm			
Box 68760, death certificate be he attending physic		IF FEMALE: 2 23b. Was decedent pregnant in the	3c. If yes, outcome of pregnant		Ectopic pregna		23d. Date of delivery Month Di	ay Year
OX 687	tor use as	past 12 months?	Pregnant at time of death	2 Fetal death 3 5 Other (Specify)	Ectopic pregna	aricy	Month Da	ay real
Boy e deatl the att	iched for use as Physician	1 Yes 2 No 9 Unknown 9	Unknown					
P.O. es that the	ਹੁ 🗖		OTRIOWIT					
	₹ ਊ	Part II. Other significant conditions cor			given in Part I.		cco use contribute to the	
S, P.C uires that	ed by	Part II. Other significant conditions cor			given in Part I.	1 Yes	2 No 3 Proba	ably 4 🗹 Unknown
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State of Maryland / Department of Health and Mental Hygiene 30472 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 135/AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death rince George's 12617 Kinder Place Bowie 8. Date of Birth
(Month, Day, Year)
Sept • 19,1943 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min Hours Director 216-40-9610 68 1 🗆 M 2 📮 Yrs. Washington D.C. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** Funeral 20715 12617 Kinder Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces 7

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Beauty Salon 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Zona Schaub Miller Dallas Hidey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Dehuarte/Spouse 12617 Kinder Place, Bowie, MD 20715 1 and 2 s of Health item 27 or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 09/04/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 autopsy performed' 2 🗌 No 1 🗌 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Yes 2 1110 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death Month Physician/ 2:15 am M 2012 eautor O Medical Facility Name (if not institution, give street and number 4c. County of Death Gity, Town, or Location of Death **Examiner** Anne Hansur Health Hamajolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday) Funeral Min Director 90 185-14-6081 1 🗆 M 2 🗶 F 6/3/1922 Pennsylvania Usual Residence of Deceden 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Tracys Landing Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 20779 USA 6271 Solomons Island Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ier than "natural", ເ t, the Medical Exam 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify. 3 √ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home 12th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emil Conrad Lydia Whittmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Briarcliffe Ct., Ocean View, DE 19970 ge 1 and 2 sh it of Health a: Cheryl J. Trainor/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or 9/7/12 Davidsonville, MD Lakemont Cemetery 4 ☐ Donation 5 X Other (Specify) Entombment al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Atheros cherosis disease or condition. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 No 1 Yes Yes To the Hospital or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 2 1 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Griffying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and title of certifier 29d. Date signed (Month, 04

Registrar
DHMH 17 Rev 06-2011

et

State

30. Name and address of person who complete

Year

2012

31. Date filed (Month, Da

6/eu Burnie

cause of death (Item 23a) (Type, Print)

Vication

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5.18 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEC AN NAPOLLS ANNE ARUNDEL MEDICAL CEMTER MARYLAND If Under 1 Year If Unde 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Aug 29 Hours Year 220-28-5097 **Director** 1 □ M 2**X** F 93 Yrs. 1919 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Anne Arundel 1 Yes 2 X No Annapolis ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1103 Smithville St. Apt 101 21401 USA items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3

Widowed 4 □ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. 8th 0 Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked other traumatic ev ဂ္ Charles Holland Maggie Diggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Collins(Daughter) 445 Collins Rd. Edgewater, Md. 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date X Burial 2 ☐ Cremation 3 ☐ Removal from State Chews UM Church 9-11-12 West River, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Windame a Reaches confeculity Sons Mortuary, 1922 Forest Dr. Annapolis, Lavr Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEARI disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be expours after death.
 Funeral Director: After this certificate has been signed by the attending physicia etely filled in by the funeral director, page 2 should be detached for use as the burnered. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Dav Year 9 I Hnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Klebsiella 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) Hospital ပ 1 Yes 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 2 DOO 69 449 09/05

Registrar

State

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M.D. 2001 MEDICAL Bokusay ANNAPOUS MD

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I			giene 201	2 30476			
	Physicia Medi		Decedent's Name (First, Middle, LALMA LORETTA BO)	,				2. Date of Dea Month	25 201	3. Time of Death 230/ M			
	Exami	er	4a. Facility Name (if not institution, gr Western MD Regi		al Center	4b. City, Town, o	r Location of Death	1	4c. County of De Allega				
	Funeral Director		5. Social Security Number 220–16–7035 Usual Residence of Decedent	Sex 7. Age 1 □ M 2 \ X F	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01/09/1	(, Year)	Birthplace (State or Foreign Country) laryland			
	ne Maryland or 28a-f show notified at	ector	10a. State 10b. County MD Alles	any	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No			
	th with the M ms 23a or 28 must be not	by Funeral Director	10e. Street and Number 13509 Bowmans I			10f. Zip Code 2154	5		10g. Citizen of What Country? U.S.A.				
	death w	Fune	11. Marital Status	12. Was Decedent E		Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race - An	nerican Indian,			
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 😿 If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🔀 No	Specify:		Black, Wh				
215-	nin 72 ho ne. han "na e Medic	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4 or 5	+) (Give	dent's Usual Occup kind of work done (O NOT use retired)	during most of wor	king	16b. Kind of Busines				
1d 21	iled with Il Hygier other t	Be	8 17. Father's Name (First, Middle, Las)	Ow	ner/Opera		ne (First, Middle,	Personal (Care Home			
rylar	nould be filed within 72 nd Mental Hygiene. s marked other than " umatic event, the Mec	ပ္	Albert Broadwat					ude O'Ha					
	1 and 2 should be of Health and Men fitem 27 is marker other traumatic	Ì	19a. Informant's Name/Relationship John E. Bowman			ng Address (Street of Box 62			City or Town, State, 2 D 21545	Zip Code)			
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State		osition (Name of matory or other place emorial P		Date 9/2012	20c. Location - City of Cumber 1	or Town, State			
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lo		. 2	2. Name and Addres		church F	uneral Hom				
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	one cause on each line		er the mode of dyin	g, such as cardiac	or respiratory arm	est,	Approximate Interval Between			
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Edio Due to (or as	consequence of):	ulmono,	y hype	Hens, a	7	Onset and Death			
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or se s	DUT BEGINS TO CTJ.		12						
	kecuted and al-transit	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):			<u>-</u>					
09,	ate be ex ohysiciar the buria	dical		d	- .								
x 687	n certific ending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2 Fetal death 3 [Ectopic pregnanc	ev.	17. 17.	23d. Date of d	elivery			
Sox	the deat by the att	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at g Unknown		Other (specify)			Month	Day Year			
s, P.O.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Part II. Other significant conditions Colonary artery (_	ut not resulting in the u	ınderlying cause giv	ven in Part I.		-	to the cause of death? Probably 4 Unknown			
Records,	law requals beer	nplete	Abrial fibrillah					24a. Was a	n 24b. Were a	utopsy findings available completion of cause of			
al Re	sician: The law r certificate has b director, page 2 s	Be Cor	14 nothers, d, 5 25. Wa se referre o medical	n T		26. Pl	ace of Death (Chec	perfor 1 Yes		es 2 No			
of Vital	ding Physician: h. After this certific funeral director,	၉	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 X Inpatie 28a. Date of injur	nt 2 ER/Outpatier		4 ☐ Nursing H		ence 6 Other (Spe	ecify)			
o uoi	eath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigati	(Month, Day,	Year) injury	work		28d. Describe ho	w injury occurred				
Division	tal or Att rs after d al Direct ed in by		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 ☐ Medical Exa	ysician: To the best of r niner: On the basis of ex rse Practitioner: To the	amination and/or inves	tigation, in my opinic	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.			
	with vith com		29b. Signature and title of certifier	111		29c. License		1	29d. Date signed (Mon				
	4		30. Name and address of person who	completed days of de	ath (Item 23a) (Type, F	Print) O.A.	1101		0.41-10	2 MD 21502			
	Nf Stat	e	31. Date filed (Mohth, Day Year)	1/3900)1, 32. Registra	MD 9		an Driv	s cum	beriend,	M) 21502			
	Registra	ır	AUG &O ZUIZ	Serve	's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 5 2012 00:24AMM Ervin C. Cleary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 Union Hospital of Cecil County E1kton 8. Date of Birth May 25, 1943 . Social Security Number Sex 1**XX**M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** North Carolina Director 219-42-6339 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No Maryland Ceci1 North East 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21901 United States 25 Creedmore Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2XXNo Specify White 3 Widowed 4XXDivorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Boat Building Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Cleary Paul Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Creedmore Lane, North East, Maryland Janie May / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September Nofther East ound tredee 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign tire thus all Solice License Methodist Cemetery 10, 2012 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home, P.A. South Main Street, North East, Maryland 21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, eau. -.
e attending physician and
ed for use as the burial-transit Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by biscular 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manne of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frederick F. Chirigotis September 11:16AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 237 Autumn Chase Drive Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 020-01-7739 1 □XM 2 □ F 94 09/12/1917 Massachusetts r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Florida Okaloosa Fort Walton Beach 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32547 610 Merioneth Drive, NE United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Black, White, etc. 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Philanthropy Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antone Chirigotis Panayota Lavakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Chirigotis/Wife 237 Autumn Chase Drive, Annapolis, Maryland 21401 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Oher (Specify St. Demetrios Cem. 09/07/2012 Annapolis, Maryland 21. Sign the of Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HEPATIC FAILURE Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner METASTATIC LIVER CANCER 3 MONTHS Sequentially list conditions, if any, leading to him reducte cause. Enter Underlying Due to (or as a consequence of): Exami eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events PROSTATE CANCER 12 MONTHS Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC COLON CANCER 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Spe 1 Yes 2 No Summer Residence မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Phatural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D09453 09/05/2012

State

Errol A. Phillip,
31. Date filed (Month, Day, Year)

2002 Medical Parkway,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar SEP 06 2012

Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Pay 1, 2012 6:08 P_M Jr. George Linwood Chaney, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Fort Washington Fort Washington Hospital 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0271971938 Mar‱1and 74 Director 577-52-0965 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's Fort Washington 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20744 7711 Wilson Way Was Decedent S. Armed Forces?

1 △ Yes 2 □ No 1955
"Yes Give 63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) **PEPCO** Draftsman Be ^{18.} Mother's Name *(First, Middle, Maiden Surn*ame) Vera Myrtle Armsworthy 17. Father's Name (First, Middle, Last) မ George Linwood Chaney, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke anyînjury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Christine Chaney - Wife 7711 Wilson Way, Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 9/7/2012 Suitland, MD Cedar Hill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. of Funeral Service Licensee 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each tipe. Approximate Immediate Cause (Final 0 Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 1 Yes 2 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide (Month, Day, Year) work?
1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Amir Mirza-Alikhani, M.D., 11711 Livingston Rd, Ft. Washington, MD 20744 State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Registrar
DHMH 17 Rev 06-2011

State

Armstrong, M.

SEP U

31. Date filed (Month, Day, Year

D.

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

14201 Laurel Park Dr. Suite 102 Laurel, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Honth Physician/ Cooper, IV John Wesley Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death Examiner Cumberland Western MD Regional Medical Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 06/23/1959 217-78-1090 Director 53 1 XM 2 □ F Maryland Yrs Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other them." any injury or other traummatic. USA 21502 411 Race Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married Yes 2 X No þ 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance State Park 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Cooper, III Jacqueline John Wesley 19a. Informant's Name/Relationship (Type, Print)
J. Jacqueline Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Codel 134 Blackiston Avenue, Cumber Land, MD 21502 / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Sunset Memorial Park 09/06/2012 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Si na ure of Funeral Se 404 Decatur Street, Cumberland, MD 23a. Part 1. Soler the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Intradisdominel disease or condition Medical resulting in death) Due to (or as a consequence of) 3day **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month been signed by the a should be detached t Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? acidos 24a. Was an Nepho is certificate has l director, page 2 s autopsy Texul Factoria Heile Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this a filled in by the funeral di 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 06-2011

State

3

29b. Signature and title of certifier

is stylian

30. Name and address of person who completed cause of death (Item Christopher Vagnoni, 1.D.,

32. Registrar's Signature

120059987

23a) Type, Print) 12500 Willowbrook Road, Cumberland, MD 21502

29d. Date signed (Month, Day, Year) 9-2-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Department of		201	2 30482						
			1 - State Registrar Certificate of 1. Decedent's Name (First, Middle, Last)		Reg. No Z U I	3. Time of Death						
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7	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town,	or Location of Death Cumberland	4c. County of D	legany						
	Funeral Director		5. Social Security Number 368-58-2269 Usual Residence of Decedent 6. Sex 1 \(\text{N} \) M 2 \(\text{X} \) F 7. Age (In yrs. last birthday) Months Days 60 Yrs.			Birthplace (State or Foreign Country) Chigan						
	rland f show d at	tor				10d. Inside City Limits						
	r 28a-	Director	MD Allegany LaVale 10e. Street and Number 10f. Zip Code		10g. Citizen of What	1 Yes 2X No						
	with the s 23a c	Funeral	882 Weires Avenue	1502		USA						
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 No	merican Indian, hite, etc.								
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Mary	d 2 should alth and M 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Nancy Chateauvert Sister 882 Weires	t and Number or Rural Route N. Avenue, LaVale	umber, City or Town, State, MD 21502	Zip Code)						
Baltimore,	Page 1 and nent of Hes int: If item iry or othe		20a. Method of Disposition 1	or Town, State nd, MD								
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	Medical Examiner		resulting in death) Due to (or a, a consequence of):	ک		Joseph Of						
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ncy	23d. Date of Month	delivery Day Year						
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۵	To the Hospital or Attenc within 24 hours after death To the Funeral Directors, completely filled in by the	Medical (
	To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. Licer	ise number	ue to the cause(s) and manne 29d. Date signed (Mo							
P	4			34362	831/20	IL						
_	nds		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy D. Chisholm, M.D., 12502 Willowbrook	Road, Cumberla	ind, MD 2150)2						
	Stat Registra	te ar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 18,2012 11:00PM M Ciarrocca Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Vantage House Assisted Living Howard Columbia Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 F Dudriey PA 94 031/90/19/19/19 317-10-9129 Director Usual Residence of Decedent show or 28a-f shov be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Columbia MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or Funeral 21045 5400 Vantage Point Road # 422 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 it.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer US Navy 12 04 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Rosina Citratdini</u> <u>Elpidio Ciarrocca</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7513 New Grace Mews Columbia, MD 21046 19a. Informant's Name/Relationship (Type, Print) Daughter Susan Lee 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 12/13/12 4 Donation 5 Other (Specify) Arlington, VA Arlington National Signature of Funeral Service Licensee 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) been signed by the a should be detached to Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medicar Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Fractioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

A Post

State

Registrar

Date filed (Month, Day

AUG 2

7 2012

#10

Dr. Andrew Lazris

who completed cause of death (Item 23a) (Type, Print)

10 James

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

29b. Signature

(Check

31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print

MEDICAL ONIOICA

strar's Signature

🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00064852

29d. Date signed (Month, Day, Year)

2003 Medical Parkway, Annapolis, MD 21401

05/2012

		AMEND 24A	Please PER VEH	e Type or Pri RBAL G932 State of M	nt in 10/26 arylan	Black II 712 TR d / Dep	ndelib artmer	le Inl	k. Ens Iealth	ure A	II Copie Iental Hy	s Are	e Legi e	ble.		
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100	}	30. Name and addres	s of person who	completed cause of c	eath (Item			5+	302 Be		mary	1	12 3		01	
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Division of Vital Records, P.O. Box 68760

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		For State	State of Marylar		artment of F <i>rtificate of L</i>			20	12 30486
Dharista		Registrar 1. Decedent's Name (First, Middle, Las	st)	067	tineate of L	ocali i	2. Date of Deat		3. Time of Death
Physicia Medic	al	John		Doughe			⊢ Manug 2	9, 2012	
Examin	er	4a. Facility Name (if not institution, give 709 Lincoln Stree	et		Cumbe			4c. County Alleg	jany
Funeral Director		5. Social Security Number 215-20-7127 Usual Residence of Decedent	ex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sep. 3,	9. Birthplace (State or Foreign Country D	
/aryland 8a-f show tified at	rector	10a. State 10b. County Allega		ty, Town or Lo Cur	nberland		,		10d. Inside City Limits 1 X Yes 2 □ No
with the As 23a or 2	Funeral Director	10e. Street and Number 709 Lincoln Street	et		10f. Zip Code	21502	1	0g. Citizen of W	Vhat Country?
I fe, IMal ylallu Z IZIS-DUSO I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Arroed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White
in 72 hour	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occupa kind of work done o O NOT use retired)		ing	16b. Kind of Bu	,
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e, Mar and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (T) Clara Dougherty	wife			Street	al Route Number, Cum	City or Town, St berland	MD 21502
permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other Specif	Removal from State	Place of Dispo cemetery, crem Mary's (sition (Name of patory or other plac Cemetery	e)	Date 9/1/2012		City or Town, State Derland MD
permit Depart Import any in		2 . Signature of Funeral Service Licens	ee	22	. ^{Name a} scarpe 108 Vii	नार्भितिक्तिका He rginia Avenue		nd, MD 215	502
Physician Medical Examiner		23a. Part I. Enter the diseaseVor companies shock for heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	e /	ins	er the mode of dying		-		Approximate Interval Between Onset and Death
E E E	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence o						
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Physician: The this certificate al director, pag	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital:	ER/Outpatien	Othe	r: 4 Nursing Ho	only one) me 5 Reside	nce 6 🗆 Other	r (Specify)
Title Ing	Certificate:	27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28b. Time of injury	28c. Injury work? M 1 🗆		28d. Describe hov	v injury occurred	d .
tal or Att	l Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Str City or Town,		r or Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2 L Medical Examin	sician: To the best of my knowl ner: On the basis of examination to Practitioner: To the best of n	n and/or invest	igation, in my opinio	n, death occurred at	the time, date and	place, and due	to the cause(s) and manner stated.
To t To t		29b. Signature and title of certifier	7.00	1.0	29c. License		29	d. Date signed	(Month, Day, Year)
6		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, P	rint)	40095	2) 4	Hugu	ST 27 2012
) (State	e	31. Date filed (Month, Day, Year) SEP 0 4 2012	ellegrino /32. Registrar's Signat	ture for a	doo (Glenn	5t. C.	mber	and Md 215
Registra	r	JEF V 4 2012	peners p.	Marie		· · · · · · · · · · · · · · · · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dolores Michelle Dicken 6:00 A August 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Oldtown County of Death Allegany Examiner 22211 Olver Beltz Road, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 03/26/1956 Country) Maryland 216-72-6420 1 M 2 X F 56 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Oldtown 1 🗌 Yes 2 🛣 No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 USA 22211 Oliver Beltz Road, SE 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond William Sciese ျှ King Marie Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22211 Oliver Beltz Road, SE, Oldtown, MD 21555 Richard L. Kennell / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 08/30/2012 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. n trui of Funeral Service bicensed 404 Decatur Street, Cumberland, MD 23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CMALL CELL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi) Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HNo မြ ER/Outpatient 3 DOA 1 Inpatient 2 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of p only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D0023371 August 29, 2012 or person who completed cause of death (Item 23a) (Type, Print)

OIKA

Qamar U. Zaman, M.D.,

12502 Willowbrook Road, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 900 William Vaughn
4a. Facility Name (if not institution, give street and number) ennison Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Regional Allegany Medical Center 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 166-32-4148 Country) 71 **Director** 1 📓 M 2 🗆 F 11-20-1940 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location at by Funeral Director traumatic event, the Medical Examiner must be notified BEDFORD HYNDMAN 1 🗷 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 119 Clarence St. PoBox 407 Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natural", or items 23a USA Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bottling Company LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam မ Dennison Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POBOX407 HYNDMAN PA 15545 Dennison 119 Clarence St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or or Burial 2 ☐ Cremation 3 ☑ Removal from State HYNOMAN Cemetery 9-6-2013 HYNOMAN PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL 21. Signature of Funeral Service Licen HOME INC 169 Clarence ST HONOMAN PA 15543 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Corona nu Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Vear Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 2 🗆 No 1 Yes Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my Rhowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ntonber 4,2012 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRS Comberland, MD GUPTA MO 625 Kent Ave, Suite 101, Sunil K.

State Registrar 32. Registrar's Signature

5 2012

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

Was allerten

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD

31. Date filed (Month Day Year)

O.C.M.E.

September 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 James Philip Finn September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's <u>eonardtown</u> 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours Director 213-24-5660 1 X M 2 - F Usual Residence of Decede 83 Maryland 1/22/1928 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director notified 28a-f Maryland | Montgomery Silver Spring ò 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? must be 23a 1220 East West Highway #722 20910 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Management Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis J. Finn Grace C. Heming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : Frances Finn-Bunales/Daughter 44564 Aspen Lane, California, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or ō 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Kathur Santivasci MO Kathleen Santivasci MO 22955 Hollywood M00872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PWEUMONIA disease or condition resulting in death) Medical **Examiner** PULLUNANY FIRROITS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IE FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P in the past 12 months? Yes 2 No be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, CHRONIC HEMMTURIA WITH ANEMIA Completed BLANDER CANCER 24a. Was an has page 2 autopsy performed' hours after death. Ineral Director: After this certificate CHRONIC KINNEY DISKASE STAGE 3 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No မ 1 ▼ Inpatient 2 □ ER/Outpatient 3 □ DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occur within 2 To the I only one) 29b. Signature and title

Maryland Veterans Cem 09/17/2012 Cheltenham, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Road, Leonardtown, MD Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, red at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTAT LOUKOUT ROAD ORIGINAL

30490

3. Time of Death

2:21

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 Tes 2 X No

State Registrar BRUCE MORSEPT GTOSON MP

DHMH 17 Rev 06-2011

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2215 Charles William Frye Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 215-26-9255 1 M 2 D F 09-22-1932 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Allegany Frostburg 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21532 U.S.A. 96 Washington Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗷 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 1951 - 196 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Inez Odgers Frye William Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
96 Washington St., Frostburg, MD 21532 Darlene Frye Wife 20a. Method of Disposition
1

Burial 2

Cremation 3

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20c. Location - City or Town, State Date 09-14-2012 Cumberland, MD 4 ☐ Conation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, Frostburg, MD 21532 60 W. Main St., 141 MOD 541 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ associated Health care disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the aftending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day detached 9 Unknown g Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Dehydration 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed. Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? P Other: 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Aatural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation completely filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 12501 Willowbrook Rd Cumberland MD21502 hirunomufa enum ad har Date filed (Month, Day, Year) State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 3 2012 Physician/ Month Peter Galt September 8:25A Medical 107 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Rockville Montgomery Shady Grove Adventist Hospital M 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days temps Hours 145-22-0971 83 Director 1 X M 2 □ F Nov. 18 1928 New Jersey 10a, State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Germantown MD Montgomery 1 ☐ Yes 2 ☑ No sep t 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12912 Poppy Seed Court 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 № Yes 2 □ No Korean Black, White, etc. 1 Never Married 2 Married Completed by 5-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White War Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Refrigeration 12 4 Mechanical Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alexander Galt Wilhelmina Calquhoun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Galt / Wife 12912 Poppy Seed Court, Germantown, 20874 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/10/12 Laytonsville, Maryland Laytonsville Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Funeral Home Souther P. O. Box 5038, 20882 Laytonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiogenic Priysiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cardiopulmonar Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami myocardio or Attending Physicien: The law requires that the deeth certificate be executed ettending physician and I for use es the burlei-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Division of Vital Records, P.O. cete hes been signed by ; page 2 should be detec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificete hes autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No |2 1 \$\frac{1}{2}\$ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending To the Hoepital or Attendin within 24 hours efter death.
To the Funerel Director: Aft completely filled in by the fur 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erepalle 71323 PX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Mon land 20550 Yenigalla MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Earnest L. Gray Sr. September 3 2012 3:32 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8104 Quarterfield Rd. Severn Anne Arundel 8. Date of Birth (Month, Day, . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 215-40-6520 Country) Maryland **Director** 1 **X** M 2 □ F 1942 Dec 69 Yrs Usual Residence of Decedent filed within 72 hours efter death with the Marylend el Hygiene. el Hygiene. 1 other then "naturel", or items 23e or 28e-f shov 10b. County ir then "naturel", or items 23e or 28e-f sho the Wedicel Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8104 Quarterfield Rd. 21144 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. چ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Truck Driver Self Employed permit. Pege 1 end 2 should be filed w Department of Health end Mentel Hygi Importent: If item 27 is merked othe eny injury or other treumetic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Gray Eleanor Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Gray(Wife) 8104 Quarterfield Rd. Severn, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, erembtory or other) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Church 9-8-12 Crofton, Md. 4 ☐ Donation 5 ☐ Other (Specify) WMame Rockies of Smill Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) To the Hospitel or Attending Physicien: The lew requires that the death certificete be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ြု 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALDR: #312, GLEN BURNIE, MD2100 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OHN DREENLEAF Month 015 M Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 1181 Summerfield Rd. Gambrills Anne Arunde1 Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 216-60-9984 Hours **Director** 1 🕅 M 2 🗆 F 60 Yrs. Apr 15 1952 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

7 is marked other then "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Gambrills 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1181 Summerfield 21054 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Divorced Specify: **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Prince George's Co Elementary/Secondary (0-12) College (1-4 or 5+) 12th Mechanic Parks & Planning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Greenleaf Sr Laura Ann Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tent: If item 27 is Keith Greenleaf(Brother) 1819 Whites Ferry Place Crofton, Md. 21114 20b. Path of Displaying Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Importent: If it eny Injury or o once, 1 X Burial 2 Cremation 3 Removal from State UM Church 4 Donation 5 Other (Specify) 9 - 14 - 12Crownsville, Md. 21. Signature of Funeral Service Licensee Miniame Alexanse of Socilis Cons Mortuary, 1922 Forest Dr. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ e disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4-Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 1 Tyes filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) |2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural
2 Accident
3 Suicide injury 5 Pending work?
1 Yes 2 No Division s after death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funerel Di Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 21438 har 04 2012 19 cm Name and address of person who completed cause of death (Item 23a) (Type, Print) NNAPOLIS MO21401 MICHAE 445 MA PFENS E 31. Date filed (Month, Day, egistrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Inez Rutter Howser Month Medical September 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 225-28-6974 Director 89 1 M 2 X F Nov. 11, 1923 Virginia and 2 should be filed within 72 hours after death with the Manyland Health and Mertal Hygiene. Health 21 is anacked other than "natural", or items 23a or 28a-1 show other traumatic event, Its Modreal Evanniner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7401 Willow Road 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Leven Adams Rutter Maude Wortman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8005 Sunnybrook Ct. Frederick, MD 21702 Curtis B. Howser / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Sept. Date 5, cemetery crematory or other place)
Resthaven
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Frederick, Maryland 21. Signature of Euneral Scryice Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause In Approximate Interval Between Onset and Death Physician/ Dneumonia Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🗌 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Pertenac 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 031643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29, 2011. Year Welkey Rocha Hogan III Medical 3:49p.m 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Min. 0370371951 California **Director** 554-78-4185 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 Tes 2 No Maryland St. Mary's Lexington Park ò 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a o Funeral 47142 Green Leaf Road 20653 United States Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 V Yes 2 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Supervisor Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Welkey Rocha Hogan II Katherine Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900441238 West 69th Street, Los Angeles, California Keisha R. Hogan/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 09/24/2012 Riverside, CA Riverside Nat. Cem. Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr.M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiae Arrythmi disease or condition resulting in death) Medical Due to (or as a consequence of Examiner HYPOXIG ninute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Day Pregnant at time of death Month Year g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has performe Yes 2 No 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending (Month, Day, Year) work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00388

State Registr<u>a</u>r

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eonardtown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan		artment of F tificate of L		and N		_	201	2 3	049
	.		Registrar 1. Decedent's Name (First, Middle)	e, Last)		061	uncate of L	Jean		2. Date of De			3. Tim	e of Death
Xin.	Physicia Medi	al	Lenny Marvin H							Septemb	per 5	, 20 ⁴ 2	1:2	0 A M
	Examir	ier	4a. Facility Name (if not institution 2433 Yarmouth				4b. City, Town, or Crofton		of Death			County of De ne Aru		
	Funeral		5. Social Security Number		e (In yrs. Ia	ast birthday)	If Under 1 Year	If Under		th	h 9. Birthplace (State or Fo			
	Director		226-50-6543 Usual Residence of Decedent	1 🕱 M 2 🗆 F	73	Yrs.	Months Days	Hours	Min.	Jan. 29	y, Year) 9, 1939 Virginia			
	land show	tor	10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside	City Limits
	e Mary r 28a-i notifie	Director	MD Anne 10e. Street and Number	Arunde1	Crof	fton							1 🗆	Yes 2 X No
	with th 23a o 1st be	Funeral I	2433 Yarmouth	Lane			10f. Zip Code 21114				10g. Citize	en of What C	Country?	
	death items ner mu		11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S		Vas Decedent of Hi Yes, specify Cuba	spanic Orig	gin? (Spe	ecify Yes or No-			nerican Indian	
36	after al", or xamir	d by	1 Never Married 2 X Mai 3 Widowed 4 Divorced	rried 1 🗓 Yes 2 🗌			Yes 2 X No		, ruerto	nican, etc.)	St	Black, Wh	white, etc. White	
2-00	hours matura dical E	olete	15. Decede	nt's Education	ATIIIY		ent's Usual Occupa					d of Busines		
121	thin 72 ine. than "	3 Widowed 4 Divorced If Yes, Give Year or Dates. Army 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) The Yes 2 (X) No 16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired) IT Tech								ng		,		
<u>d</u> 2	led wil I Hygie other ent, th	Be C	17. Father's Name (First, Middle,	Last)		11 16	CII	18 Mothe	er's Name	e (First, Middle,		uters		
Maryland 21215-0036	d be fi Mental arked atic ev	은	Thomas	Clyde Hollan	d					lo11and	maraen oa	marrie		
Man	shoul h and l		19a. Informant's Name/Relations			1	g Address (Street a							
e,	and 2 Healtl tem 2		Patricia E. Ho 20a. Method of Disposition	lland / Daug			Yarmouth sition (Name of	Lane		Crofto			or Town, State	
mo	Page 1 nent of ant: If i		1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other 6		CE	emetery, crem	atory or other place	^{e)} 9	/7/2			imore,		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	icensee			Name and Addres			Beall F	unera	al Hom	ne	
			23a. Part 1. Enter the disease, of	complications that caused	the death		12 NW Cr				rie, N	1D 20)715 Approxir	note.
	Physician/		shock, or he at failure. List of Immediate Cause (Final disease or condition	only one cause on each line		ılar di					•		Interval E Onset ar	Between
	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								<u>_</u>
		Jer	Sequentially list conditions,	b. Conges			failure							
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
_	ate be executed ohysician and the burial-transit	al E	resulting in death) Last	Due to (or as a	conseque	ence of):								
1200		ledical		d										
Box 68	death certifice ne attending p ed for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnancy	,			23	d. Date of de	elivery	
	e e e	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5	Other (specify)					Month	Day	Year
P.O.	The law requires that the ate has been signed by the page 2 should be detach	by Ph	Part II. Other significant condition	ons contributing to death bu	ut not resu	ulting in the un	derlying cause give	en in Part I.		23e. Did to	bacco use	contribute t	to the cause o	f death?
ds,	v requires that to been signed be should be detail	ted k	COPD							1 🗆 ነ	′es 2 X	No 3 🗆 f	Probably 4 [Unknown
SCOL	law re has be re 2 sh	Completed								24a. Was a autop	sy	prior to	utopsy finding completion o	
Division of Vital Records, P.O.	sician: The law scrifficate has k		25. Was case referred to medical				00 74	(0.00	(0)	1 🗆 Yes	med? 2 A No	death?	es 2 🗆 No	
Vita	Physician: this certific al director,	To Be	examiner? 1 Yes 2X No	Hospital:	nt 2 🗆 E	ER/Outpatient	Othor	ce of Death		only one) me 5 🕱 Resid	ence 6	Other (Spe	ncifu)	
) of	or Attending Physician: after death. Director: After this certific in by the funeral director.		27. Manner of Death 1 X Natural 5 Pendir	28a. Date of injur	у [2	28b. Time of injury	28c. Injury work?	at	2	28d. Describe ho			iciry)	
Sior	or Attending Paffer death. Director: After t	Certificate:	2 Accident Investigned 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident 1 Accident	not be 200 Place of Injur	rv - At hon	ne, farm, stree		Yes 2 🗌 I		28f. Location (Si	tmot and M	tumbar ar D	unal Davida Nive	- ha -
Σ	tal or /		4 ☐ Homicide determ	building, etc.	(Specify)				ľ	City or Town		urriber or Hi	urai noute ivui	nber,
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	To the within To the comple	Σ	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	best of my	y knowledge, c	29c. License		and place				as stated. th, Day, Year)	
			► lupae	591)			D00509	951			9/5/2	2012		
~ !	#34V		30. Name and address of person Reva Gill, 65	who completed cause of de 10 Kenilworth	ath (Item 2	23a) (Type, Pri	. 2400, I	River	dale	, MD 2	0737			
	Stat Registra	-	31. Date filed (Month, Day, Year) SEP 06	2012 32. Fegistrar	's Signatu	d.	we							
	negistra	•	JEF 00	Color	- /	- 7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SMORTH Year R'THUK 5.48AM TOLINES 012 Medical 4a, Eacility Name (if not institution, give street and number) 4c County of Death' Ballimore **Examiner** 4b. City, Town, or Location of Death Howen CasorSVILA Jursma If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In vrs. last birthday) **Funeral** Min. 205-26-8278 79 Director 1 🏻 M 2 🗆 F May 31, 1933 New York 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Anne Arundel Annapolis 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2539 Mission Hills Ct. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. ori þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) the Private Practice Medical Doctor other traumatic event, Be Department of Health and Montal H Important: If item 27 is marked any injury or others 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence L. Holmes Ruth R. Altvater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2539 Mission Hills Ct., 21401 Janet M. Holmes / Spouse Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 9/10/2012 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Beall Funeral Home Licen: 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the sease, or complications that caused shock, or he failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final THEROSCLEROTIC Physician/ EREBRO VA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ been signed by the atter should be detached for in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUPERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy prior to completion death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No the f Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29d. Date signed (Month, Day, Year) J25635 mi well 30. Name and address of person who completed cause of death (Item 23a) (Type, Prince of Action 23a) (Type, Prince of Action 23a) WINGS 1525 AICHANI MILL MI 06 2012

DHMH 17 Rev 06-2011

State Registrar

		,	State	epartment of Health and l		ene a. No. 2012	2 301.99				
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Lucy Ann Wood Hughes	3	2. Date of Death	Day 2012	3. Time of Death 9:33 P M				
	Exami		4a. Facility Name (if not institution, give street and number) 8902 Ft. Foote Road 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	4b. City, Town, or Location of Death Ft. Washington	1	4c. County of Dear Prince G	eorge's				
	Funeral Director		5. Social Security Number 223-40-1729 6. Sex 7. Age (In yrs. last birthda) 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 02/13/19	9. Bir Co	thplace (State or Foreign untry) Virginia				
	Maryland 28a-f show otified at	irector	Maryland Prince George's Ft. W	Location Vashington			10d. Inside City Limits 1 ☐ Yes 2XXNo				
	h with the ns 23a or must be n	Funeral Director	10e. Street and Number 8902 Ft. Foote Road	10f. Zip Code 20744	10g	. Citizen of What Co	•				
-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed by Fu									
Maryland 21215-0036	I within 72 h /giene. ner than "na t, the Medic			cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired) OMESTIC	king	b. Kind of Business/Self Empl	,				
ryland	uld be filed I Mental Hy narked ott	To Be	17. Father's Name (First, Middle, Last) Stuart Wood	18. Mother's Nam Fanni	ne (First, Middle, Maid e Broad	,					
e, Mai	and 2 sho Health and em 27 is r ther traun		Maxine H. Barron / Daughter 890	alling Address (Street and Number or Run 2 Ft. Foote Road F	t. Washing	gton, MD	20744				
Baltimore,	Page nent c ant: If ary or		1 Burial 2XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas	Crematory 07 other place) Crematory 08/2	.5/2012 Ed	c.Location - City or december ,	Maryland				
Ba	permit. Departr Imports any injs			22. Name and Address of Facility Ge 6160 Oxon Hill Rd.	Oxon HIL	ılas Funeı L, Maryla	ral Home PA nd 20745				
- de	Physician/ Medical		23a. Part 1 Enter the disease, or complications that caused the death. Do not en show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of:	ent fullence of dying, such as cardiac of the mode of dying, such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as cardiac of the such as	or respiratory arrest,		Approximate Interval Between Onset and Death				
***	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)				,				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
68760	eath certificate attending phys	/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								
D. Box	es that the death or signed by the attent be detached for u	hysicia	in the past 12 months? 1	Other (specify)		23d. Date of deli Month	very Day Year				
ds, P.O.	requires that been signed should be de		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?				
Records,	: The law re cate has be ; page 2 sh	Completed by			24a. Was an autopsy performed 1 Yes 2 X	? prior to co	oppsy findings available ompletion of cause of				
of Vital	ysician: The is certificate director, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check	(only one)						
) <	Phys r this eral di	2	27. Manner of Death		me XX Residence		(y)				
Division o	Attending I r death. ector: After by the funer	Certificate:	1XX Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No	28d. Describe how in						
Div	ospital or Attend hours after deatl ineral Director.	ᡖ┝	29a. Certifier 1 XX certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	28f. Location (Street City or Town, Sta	ate)					
	To the Hos within 24 ha To the Fun completely		(Check 2 ☐ Medical Examiner: On the basis of examination and/or inversionly one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	Stigation in my opinion death occurred at	the time, date and pla	1 1 1 11	ause(s) and manner stated. stated.				
9	, %	3	30. Name and address of person who completed cause of death (Item 23a) (Type,	D27521	234.1	8/24/12	- roar				
	W State		Kadie E. Leach MD 9500 Annapo	lis Rd. #A1 Lanham	, Marylan	d 20706					
	Registra	r	31. Date filed (Month Day Year 2012 2. Registrar's Signature	de							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland / Department of Health and Mental Hygiene												
			Registrar		Certificate of Death									. 20	2	3050
	Physicia	an/	1. Decedent's Name		•							2. Date of Dea	ath Da	ay Yea	ır	3. Time of Death
mark.	Medi		Stanley 4a. Facility Name (if	Joseph J		4						Septemb	per	6, 201		12:35A M
	Examir	ier				•				Location o			4c	. County of De		
	Funeral		5. Social Security No	ke Shores		Age (In yrs. la	ast birthday)			ton P		8. Date of Birt	h	St. Ma		
	Director		181-12-4	142 1	Ми2□F	. ,	90 Yrs.	Months	Days	Hours	Min.	(Month, Day		, , , , , , , , , , , , , , , , , , , ,		
	D W	1	Usual Residence o	of Decedent								08/26/	1922	2 Pi	Ltts	sburg, PA
	-f ah	턍	10a. State	10b. County		10c. City	y, Town or Loc	ation							10	d. Inside City Limits
	r 28e	흥	MD 10e. Street and Num	Charles	3	Hugh	nesvill									1 Tes 2 No
	ith th	를						10f. Zip					10g. Cit	tizen of What	Countr	у?
	ath w	Funeral Director	16325 P	rince Fre	derick R		112 14	206			1-0.40	'' N		USA		
ဖွ	or its	DY F		ied 2 🗆 Married	Armed Forces	s?	If	Yes, speci	ify Cuban	n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi		
Š	raff.	8	3 🕅 Widowed		If Yes, Give Year or Dates		1	☐ Yes 2	2Å No	Specify:			- 1	Specify: W	hit	:e
Maryland 21215-0036	2 hou "natu	Completed	(Spe	15. Decedent's Ed	ducation		16a. Deced	ent's Usua	Occupa	tion			16b. K	(ind of Busines	ss/Indu	ustry
2	hin 7; ne. than	E	Elementary/Seco		College (1-4 o	or 5+)	life. DC	ONOT use	retired)		of workir	ng				,
7	d wit tygie ther nt, th	Bec	12				Distr	ict N	lanag	ger			Con	venien	ce	Store
anc	ntai H	70 E	17. Father's Name (F						- 1			(First, Middle,		Surname)		
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ē	1 and 2 s of Heeith item 27 i		Linda A. 20a. Method of Disp	Javorski position	/ Daught		P.O.			Hugh		11e, M				
9	age onto			Cremation 3		te CE	emetery, crem	atory or ot	her place	7 .		ate		ocation - City		·
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Heelth and Mantai Hyglene. Important: if item 27 is merked other than "natural", or itema 23e or 28e-f show with injury or other treumetic event, the Medical Examiner must be notified at ances.	4 Donation 5 Other (Specify) Trinity Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility B								09/1	0/2012	Wa1	dorf,	Mar	yland	
ä	Depermine any ir.		Lar	itm CE	cholo #	M00817	_]	0193	THE	e not	cn r	a, Una	arıo	ols F. tte Ha	Н., 11,	P.A. MD 20622
			23a. Part 1. Enter the shock, or hear	e disease, or comp failure. List only o	olications that caus ne cause on pach I	ed the death ine.	n. Do not ente	the mode	of dying	, such as o	cardiac or	respiratory arm	est,			Approximate nterval Between
	Physician/ Medical		Immediate Cause (f disease or condition resulting in death)	-inal	a	naes	tre 1	lear	* I	ail	1110)				Onset and Death
1	Examiner		resulting in death)	ſ	Due to ter a	s a conseque	ence of):	- 0.								
		10	Sequentially list cor if any, leading to im	nditions,	b. Due to (or a	s a conseque	Y a	lelle	u						╄	
	red insit	直	cause. Enter Under Cause (Disease or in	tying njury	Due to (or a	s a consequi	ence oij.									
	xecu n end ai-tre	EX	that initiated events resulting in death) L		C. Due to (or a	is a conseque	ence of):								╁	
Ö	cate be executed physician end s the burial-trensit	edical Examiner		L	d.											
8760			IF FEMALE:		·											
Ø ×	h cert tendir rr use	an/	23b. Was decedent p in the past 12 m	progricuit	23c. If yes, outcom 1 Live Birth	e of pregnan	ncy Ideath 3	Ectonic or	regnancy.					23d. Date of d	lelivery	,
Box 68	ss thet the death certific igned by the attending be detached for use as	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 Pregnant	t at time of de	eath 5	Other (spe						Month	D	ay Year
o.	et the		Part II. Other signific	cant conditions or			data — ta ab —	4-4-5								
<u>ر</u>	es th	1 by	de la constant	Suite Conditions Co	antibuting to death	but not resu	alang in the un	idenying ca	ause give	n in Part I.						cause of death?
Ĕ	require been si should	ete	-									1 🗆 Y	es 21	No 3 □	Probat	bly 4 🗌 Unknown
Division of Vital Records, P.O.	has has	Completed										24a. Was a autop:	sv	prior to	comp	y findings available pletion of cause of
ď	ilclan: The ia certificate ha rector, page i		25. Was case referre	d to medical								perfor	medi 2 [XNo	death?		□No
/ita	ysician: is certific director,	0	examiner?	. h	Hospital:				ONL	e of Death						
£	y Phy or this erei d	9: To	27. Manner of Death		28a. Date of in	jury :	ER/Outpatient 28b. Time of		c. Injury a	4 La Nur	rsing Hom	ne 5 🗆 Reside	ence 6	Other (Spe	ecify)	
Ĕ	Attending ir death. sctor: After by the fune	Certificate:	1 Natural 2 Accident	5 Pending Investigation	(Month, D	ay, Year)	injury	м	work?	es 2 🗌 !		3d. Describe ho	ow injury	occurred		
isic	Atte er der ector by th	ıtit	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Ir	njury - At hor	me, farm, stree				-	8f. Location (St	reet and	Number or B	ural Ro	oute Number
슬	ital or irs afte al Dir ied in				building, e	etc. (Specify)						City or Town	n, State)		a , a, , , ,	ato Namber,
	Hoapi 4 hou Tuner tely fii	Medical	29a. Certifier 1 (Check 2	Certifying Phys Medical Examin	ician: To the best oner: On the basis of	of my knowle	edge, death oc	curred at t	he time,	date and p	olace, and	due to the cau	ıse(s) an	nd manner as :	stated.	(s) and manner stated.
	# # # # #	Σ	only one) 3 29b. Signature and ti	- Octalying Mais	e Practitioner: To t	the best of my	y knowledge, o	leath occur	red at the	time, date	and plac	e, and due to th	e cause(s) and manner	as stat	ted.
_	5 <u>₹</u> \$ §		29b. Signature and ti	tie of certifier	200	1		29c. l	License n	number	5	~/ 2	9d. Date	e signed (Mon		- 1
U	•		30 Name and add-	as of person	UUV(00-1-7		711	000	21	01	UC	1-00	-	2012
4	+1 Rme		30. Name and addres Jennifer								4.		0.5	6.50		
	Stat	e	31. Date filed (Month	Day, Year)	32 Regist	trar's Signatu	ire.		ne.	Leona	rdto	wn, MD	20	650		
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